103

S. HRG. 103–428

MENTAL HEALTH AND THE AGING

Y 4. AG 4: S. HRG. 103-428

Mental Health and the Aging, S.Hrg....

FORUM

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

WASHINGTON, DC

JULY 15, 1993

Serial No. 103–10

APR 19 1994

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

72–460 WASHINGTON : 1993

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-043672-9

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FORUM ON MENTAL HEALTH AND THE AGING

THURSDAY, JULY 15, 1993

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The forum was convened, pursuant to notice, at 10 a.m. in room 562, Dirksen Senate Office Building, Hon. David Pryor (Chairman of the Committee) presiding.

Present: Senators Pryor, Cohen, Simpson, and Wellstone.

OPENING STATEMENT BY SENATOR WILLIAM COHEN

Senator COHEN. Ladies and gentlemen, would you please take your seats. This is not a Republican coup attempt to take over this proceeding in the absence of Senator Pryor. I believe he will be here momentarily, but in view of the fact that we have Mrs. Gore with us today, we thought we would try to start as reasonably close to on time as we could.

I want to welcome all of you and thank you for attending this morning's forum. The focus of course is going to be on the mental health needs of our Nation's elderly. I am particularly pleased that Tipper Gore has been able to join us. She has been a valiant crusader on behalf of millions of Americans with mental illness and their families, and we are very fortunate to have her with us today.

One of the most daunting challenges that faces our public health system is how we are going to finance and improve the quality of care for the millions of Americans with severe, disabling mental disorders that can devastate not only their lives, but the lives of their families as well. The experts estimate that one in five Americans are going to suffer from mental illness at some point in their lives, as many as 40 million people in any given year. Equally disturbing are the statistics that reflect the prevalence of mental illness in our Nation's elderly. Some 15 percent of Americans over the age of 65 suffer from significant mental health problems and an estimated 80 percent of the elderly persons in nursing homes have some degree of mental impairment. Particularly alarming is the fact that Americans over 65 are more likely to commit suicide than any other age group.

The most prevalent mental disorder afflicting older people is depression. Ironically, while recent advances have been made, depression is an eminently treatable disorder, only a minority of elderly depressed individuals are receiving adequate treatment. And more disturbing is the fact that the vast majority of the depressed elderly don't even bother to seek help. Most simply accept their feelings of profound sadness and they don't realize that they are clinically

depressed. And many of those who do seek help are often underdiagnosed or misdiagnosed, leading the National Institute of Mental Health to estimate that 60 percent of depressed older Americans are not receiving the treatment they need, placing them at increased risk of disability, even suicide.

With the onset of old age we face a number of what some might term necessary losses. We start losing loved ones, we may lose a spouse, we start losing physical strength and incuring a number of physical impairments, all of which tends to add to the stress that can lead to depression and mental impairment. Another component of this is that not only as the individual is suffering from this type of impairment, but the people who he or she relies upon, the family members, also may be reaching a stage in life where they are undergoing tremendous stress or impairments, physical or mental, causing them to accelerate their own level of decline. So if this is left untreated, then serious mental illness cannot only be disabling but life threatening.

I would like to just offer you one quote before yielding to this wonderful panel that we have here. I am actually conducting a mini filibuster until Senator Pryor gets here.

And it is one that even Democrats would support, I might add. A very positive filibuster. Vincent Van Gogh once wrote a letter to his brother Theo and he said in that letter, "As for me, you must know that I shouldn't precisely have chosen madness if there were any other choice. What consoles me is that I am beginning to consider madness as an illness like any other and I accept it as such." Modern science has since confirmed Van Gogh's intuitive understanding of his own disease and the research now shows that many severe mental illnesses are biologically based. They are treatable disorders of the brain, and it is therefore time to put an end to discriminatory health care coverage policies.

I don't see Senator Pryor on the horizon, but let me just add one final note before yielding to Mrs. Gore. We are about, hopefully, to receive the President's recommendation for health care reform in this country. It has been delayed from May to now and hopefully we will see it in September. There are a variety of reasons for the delay no doubt, some budgetary, some perhaps political, some simply because of the complexity of the issue involved. Nonetheless, I think that this is one area where we cannot afford to try to strike partisan positions. The health care reform effort underway must and should enjoy bipartisan support, and one element of that has to be the inclusion of some kind of coverage for serious mental health illness. That is something that Senator Domenici and others on our side and myself are going to work very hard to include. I know it is a subject that Mrs. Gore is working with Mrs. Clinton and the President to see to it that becomes part of the administration's recommendation.

So with that, I am announcing the end of my filibuster. I am going to read what Senator Pryor has prepared for an introduction for Mrs. Gore. I will read that now and then I am going to yield the floor to her so she can address you.

Mrs. Tipper Gore, who served as a mental health advisor to the President's Task Force on Health Care Reform, has a long-standing involvement with mental health issues. She is committed to help-

ing develop a health care system that includes affordable, high quality mental health care. Mrs. Gore is the founder of the Tennessee Voices for Children which is a coalition to promote the development of services for children with mental health problems. She is also a co-founder of the National Mental Health Association. Mrs. Gore has both her undergraduate and graduate degrees in psychology—I hope you are not analyzing the speaker as we proceed at this moment.

And so she brings not only an interest and commitment to these issues, but a great deal of expertise.

So we are indeed deeply honored to have Mrs. Gore with us today. I now yield the floor to her.

Welcome and thank you.

STATEMENT OF TIPPER GORE, KEYNOTE SPEAKER

Mrs. GORE. Thank you, Senator Cohen. It is very interesting that we would view each other a little suspiciously because of our interests. He is worried that I might be analyzing him and I told him that we had just moved into the Naval Observatory and I said we're going to look forward to your coming over. And he said, "Yes, and I may set my next novel 'Murder in the Vice President's Mansion'".

But thank you very much for the introduction and most especially for conducting this forum and for talking about all the reasons that it is so extremely important. It is important in terms of health care reform, in terms of mental health coverage in health care reform, and I am delighted to be here and I am delighted that you and the Committee members and the Coalition have chosen to focus on the discussion of mental health and the elderly as an important subset of mental health care.

The Special Committee on Aging has always had—always had—a receptive ear for mental health issues and the elderly, and for that you are to be commended. As you were making your remarks about the importance of this issue and how it affects older Americans, I was reminiscing about one of our family stories that my mother-in-law, Pauline Gore, tells to the grandchildren that was about her mother. As her mother got older, one of the grandchildren once said to her, "Tell us about what life used to be and then tell us what is it you miss the most." And she paused a minute and she said, "Well I miss my mind." So that is a little bit funny but then again it isn't funny because it speaks to some of the issues that affect the elderly and it speaks to the pain. I kept thinking how would I feel if I had to say that to my grandchild. So I congratulate you on your wisdom and your willingness to address this very important area.

In our great country we have 8,000 people who celebrate their 65th birthday every year. And between the years 2010 and 2030 the number of people over age 65, which will include the Vice President and myself and of course you all, will increase by 73 percent, that is a huge number, while the population under age 65 will decrease by about 3 percent. So it is obviously a time to think, to capitalize on the tremendous assets of all elderly Americans and we must make productive aging a national priority. It is certainly

something that is in our interest, not to mention the fact that it is the right thing to do for our older constituents now.

For millions of our Nation's elderly the greatest threat to their health and quality of life and well-being may not be cancer or heart disease, but instead, as Senator Cohen alluded to earlier—depression, anxiety, loneliness, poverty, and a lack of accessible, affordable health care. Like many other health disorders, these emotional difficulties are fraught with pain and isolation and often lead to destructive behaviors and in some cases can even be fatal. I know Dr. Robert Butler and others have written about sort of chronic suicide of older people who just slowly give up. Yet because of the stigma that has long been associated with mental illness in our society, these health problems go untreated and undetected. The elderly are particularly subject to under-treatment because they often experience the limited accessibility to affordable health care.

And further complicating health treatment for the elderly is the prevalence of co-existing physical and mental illnesses which often goes unrecognized. As a result, attention may be focused on the physical ailments without regard for contributing emotional factors. So correcting the underlying misperceptions regarding mental illness and mental health care is critical in eliminating the stigma and increasing the delivery of quality care.

I can remember in Tennessee one of my friends who was a therapist just lived next door to an elderly man. He had lost his wife and just one day over the hedge he started talking to her about the fact that he just didn't have any energy anymore and he was fatigued. She thought, well, it really sounds like he is depressed. He was in his 80's. So she suggested to him that he might be depressed, and that it was very simple if he got the right diagnosis that with a certain medication he would be feeling better. He went ahead and went to the doctor and 2 weeks later he leaned over the hedge and said "Thank you so much. This has made all the difference. It turns out I was depressed."

Most elderly persons do lead full and productive lives. I have to quote one of our more famous elderly people in America, George Burns. He once said, "Retire? That's ridiculous. What it does for you is to have something to get up for in the morning." Unfortunately, a significant portion of our elderly, really estimated at between 10 percent and 25 percent in a given year, have mental health problems that compromise their ability to be productive. Again, these include depression, suicide, alcohol abuse, and dementia.

Much progress has been made regarding the treatment of elderly persons experiencing mental health problems which enables them to lead vital and satisfying lives. Research in this area is to be credited. Research has yielded a great deal of agreement regarding the diagnosis and treatment of many disorders. However, continued research is necessary to explore those mental health issues unique to the elderly as they process all kinds of medications differently, and that is something that we've learned recently. For example, it is imperative that we understand the complex interrelationships between physical and mental illnesses in order to develop effective interventions. And exploring ways to help older Americans effec-

tively cope with loss, as Senator Cohen mentioned, treat existing diseases and prevent future illnesses is also necessary.

Emphasizing the implementation of home and community-based care options tailored to the needs of the elderly is absolutely essential. And finding ways to train both formal and informal caregivers to respond to the unique needs of the elderly in a sensitive and appropriate manner is also critical. The precious assets of older Americans warrant the discovery of ways to capture and renew and keep going their unique talents.

I look forward to hearing today's panel discussion and to learning more about the current advances and the status of where we are in treating our elderly and where we need to think about going. With continued support and advocacy from members of the Committee and the Coalition, I have great hope that the mental health needs of all Americans, and especially our Nation's elderly, will be met with the compassion and respect that they deserve.

Thank you very much for the opportunity to be here with you.

STATEMENT OF SENATOR DAVID PRYOR, CHAIRMAN

The CHAIRMAN. This just goes to show that this is a bipartisan, nonpartisan Committee. I was late and I understand Senator Cohen made a remarkable introduction of Mrs. Gore. We are very appreciative of that. I have often said that Senator Cohen is not only one of our finest Members of the Senate, he is one of the great introducers of the Senate. We do appreciate him and of course second to none is our colleague, Senator Alan Simpson of Wyoming.

If I might, I would just like to take a moment to personally welcome Mrs. Gore to our forum this morning. Some people, Mrs. Gore, sometimes call this a workshop; this is a little larger than a workshop. But it is not a hearing. Many times in this Committee we feel that in a hearing that the setting is too formal, that we get up and read opening statements, and then we call witnesses up and they have their statements, we ask a few questions, they are excused. So we want to have more participation and so we came up with the concept of the workshop, which is a smaller group, the forum, which is a little larger group, as alternatives to what they call the formalized hearing.

When we thought about having a forum relative to mental health and the elderly, the very first person that came to our mind was the wife of the Vice President, Mrs. Albert Gore, to see if it might be possible that she could give a few moments of her busy schedule to come and participate with us, share her thoughts, and also to listen to others as we proceed during the morning forum. We are so indebted to you, Tipper, for giving of your time so generously and of your staff in helping us make this forum possible and certainly making this, I truly believe, a real success.

Senator Simpson, I don't know if you are aware but Mrs. Gore has her undergraduate degree in psychology. She has her graduate degree in psychology. I think that is a perfect combination for a politician's wife, psychology.

I think that this really helps prepare her to help our Vice President as he proceeds during the next 3½ years about his very important duties.

We have assembled an outstanding panel this morning. We have, as one of our moderators Nancy Coleman. Nancy, is the chairperson of the Coalition on Mental Health and Aging, and is from the Commission on Legal Problems of the Elderly at the American Bar Association.

Dr. Barry Lebowitz is the Chief of Mental Disorders of The Aging Research Branch of the National Institute of Mental Health. He is also an adjunct professor in the department of psychiatry, Georgetown University School of Medicine. We welcome him today.

Joining our group is Dr. Larry Rickards. He is director of intergovernmental initiatives—not relations but initiatives—in the Health and Human Services Department, the Center for Mental Health Services and Homeless Programs section.

We are very excited not only to have you as our moderators, but to have you, Mrs. Gore, as our special guest and participant and also to have our good friend and colleague Senator Simpson of Wyoming who I am going to introduce at this time and then we will yield to our panel to begin our program.

Senator Simpson of Wyoming.

STATEMENT OF SENATOR ALAN K. SIMPSON

Senator SIMPSON. Mr. Chairman, I thank you very much. You and I came here together to this place. I do know Mrs. Gore, indeed I do. She and my wife Ann have been deeply involved in this issue of mental health, the Alliance for the Mentally Ill. Tipper was fine enough and generous enough to come to Wyoming to my home town of Cody and she and Ann participated in the most extraordinary event which still is being discussed and talked about in the most positive ways out in Wyoming. You made a special effort to do that and I so admire you, you know that. I've told you privately and I've told you publicly you are an extraordinary woman. I do so appreciate what you do. If anyone that knows Dave Pryor and Al Gore and Al Simpson, they would know very well that without Barbara Pryor and Tipper Gore and Ann Simpson we would be wandering in the wilderness.

And so I do admire that. You are very supportive to us and you are very authentic and sincere in your work. We have tough problems. The First Lady is suggesting coverage of severe mental illness. What is that? And then we know that the illness of mental illness leads to physical illness. No way to equate that as we deal with health care. But wherever we're headed, it is good to know that you are there in the forefront of it. I am very pleased to see this forum and thank the Chairman and Bill Cohen for that. I have been on this Committee and we do good things. We can't legislate but we listen and we do good things. I thank you so much.

The CHAIRMAN. Thank you, Alan, very much.

Let me also rise on a point of personal privilege. When we are talking about staff and support, we could not run this place without the wonderful staff that we have and the Special Committee on Aging in the Senate is very fortunate to have a new staff director, Theresa Forster. Theresa, would you please stand. I know that many of you know Theresa. Theresa started with the Aging Committee back in the 1970's in the mail room.

I did not say travel office, now, I said mail room.

She has been on our staff, my personal staff, she has been out in the real world working with some of the fine organizations that have been supportive of our efforts here, and last month she joined us as staff director after Portia Mittelman, our then staff director, was hired by Donna Shalala in the Department of Health and Human Services. We hated to see her leave but we are very proud to have Theresa back with us in this capacity.

Now, I think I am going to turn our program over to Nancy and we will start from there. Soon, I will sort of evaporate but I am going to sit right back here and listen for a few minutes.

Nancy, would you like to take over.

STATEMENT OF NANCY COLEMAN, FORUM MODERATOR

Ms. COLEMAN. Thank you Senator Pryor. I would like to commend the Senate Special Committee on Aging for holding this forum on mental health and aging today. We are going to be somewhat informal today. The goals for today's forum are to explore the needs of the elderly for mental health services. The appropriateness of today's treatment modalities, and to come to some understanding as to how those are paid for. Dr. Barry Lebowitz, who is at NIMH and who has written a great deal on the subject of today's forum is going to start off with a few comments and then we are going to ask our first panel to join us. We hope that there is an opportunity to have questions with all of the participants here today.

Dr. Lebowitz.

STATEMENT OF BARRY LEBOWITZ, CHIEF OF THE MENTAL DISORDERS OF THE AGING RESEARCH BRANCH, NATIONAL INSTITUTE OF MENTAL HEALTH

Mr. LEBOWITZ. Thank you, Mr. Chairman, Senator Simpson, Mrs. Gore. It is a great privilege and honor to be here. I see that there are a number of younger people in the audience so let me remind you of a little history, and that is that more than 20 years ago this Committee under the leadership of its chairman, the late Frank Church of Idaho, issued a series of reports on the mental health of older Americans that really set the agenda for us and called for a greater national attention to these important issues.

I am pleased to say that in the more than 20 years since those reports there has been tremendous, tremendous development. We have seen a major field of specialization emerge, one that attracts the best of contemporary science, education, and clinical practice. Research centers focusing on the mental disorders of older persons are established all over the country. Textbooks, specialized journals and scientific societies, all indicators of a major field of endeavor have been established.

The period has also seen remarkable stability. In 1974, the first national program on mental health and aging was established at the National Institute of Mental Health. Since that time there have been two directors of that program, Dr. Cohen who established the program, and myself, and we're both on your program today. So we have growth, we have change, we have development and we have stability.

Now what do we know? We know that mental disorders are widespread among older persons. Of the 32 million older Americans, about 4 million suffer from dementing disorders, about 5 million suffer from serious and persistent symptoms of depression, another million suffer from major depressive disorder. Prevalence is particularly high in nursing homes and other residential care facilities where more than 2 of every 3 of the 1.5 million residents of nursing homes have diagnosable mental disorder. These mental disorders are serious public health concerns. It is not normal to be depressed, it is not normal to be sick. These are illnesses that can be recognized with diagnostic procedures that have been as well-validated as any other area of medicine so that we can accurately recognize these disorders and initiate treatment.

The treatments for these disorders are available, safe, and effective. The data on the efficacy of treatment for mental disorders has transformed the debate on health care reform in this country. And under Mrs. Gore's leadership, we have squarely put mental disorders at the center of policy development in health care reform.

But the basic data is that we can be as effective in the treatment of mental disorders as any other area of medicine; in fact, in many areas we are more successful with the results of randomized controlled clinical trials, not clinical impression, not opinions, not best practice, but randomized controlled clinical trials. But what we have learned is that a mental illness is not like a bout of the flu, that when you treat it it goes away. Like diabetes, arthritis, and other common disorders of older people, mental disorders are chronic, recurring, require long-term treatments accompanied by life style changes and commonly by environmental manipulations as well.

Well where do we go from here? We expand the notion of long-term treatment. We focus more on these complex co-morbidities and co-existing physical and mental illnesses. We derive what we can from the important developments in basic science that are emerging from the Decade of the Brain and other international initiatives. And we follow the dictum of Dr. Koop, our former Surgeon General, who warns us that inadequate attention to biomedical research is dangerous for all our health.

Thank you.

[The prepared statement of Mr. Lebowitz follows:]

National Institute of Mental Health

Fact Sheet:

Mental Disorders of the Aging Research Branch
Barry D. Lebowitz, Ph.D., Chief

Alcohol, Drug Abuse and Mental Health Administration
Public Health Service
U.S. Department of Health and Human Services

Mental Health & Aging:

Scientific Discoveries and Prospects

Research to discover the causes of and to elucidate treatments for mental disorders in the elderly began to flourish only in the past 10-15 years. Prior to that time, the scientific community evidenced remarkably little interest in the study of behavioral and psychiatric disorders that are associated with growing old or being old. Thus, the knowledge base a decade ago reflected more ignorance than understanding.

Although the public and scientists alike always hope for dramatic "research breakthroughs," the process of developing new scientific knowledge usually comes in slow steps. These steps may be divided into three phases: recognition, association, and discovery. **Recognition** refers to the process of clearly defining the subject under study, beginning to separate it from other disorders in a predictable or repeatable fashion, and appreciating the influences that confound or obscure the subject's distinction from other disorders. **Association** involves systematically linking the occurrence of a disorder with other consistently related clinical, psychological, social, or biological features. The **Discovery** step allows scientists to discern "cause and effect," "specific treatment," and, finally, "cure."

Research involving the major mental disorders of aging and old age has made substantial progress along the continuum of recognition, association, and discovery. At the same time, investigators have begun to elucidate the factors that contribute to sustained mental health during the aging process, the ultimate goal of all investigations in this field.

Four major classes of mental disorders account for the majority of illness, disability, and health care costs among older patients: dementia, delirium, mood disorder, and psychosis. While other mental conditions are also present in the aging population, the greatest effort in recent years has been devoted to the investigation of these most severe and debilitating problems.

Dementia

Perhaps the most significant progress has come in the study of dementing disorders, particularly Alzheimer's disease. During the 1970s and early 1980s, scientists improved their ability to clarify the diagnosis of Alzheimer's disease and to understand the many behavioral symptoms that accompany the characteristic progressive decline in intellectual abilities associated with the disorder.

Indeed, while still not a curable illness, Alzheimer's disease is now more readily diagnosed and treated. Behavioral symptoms associated with Alzheimer's (e.g., depression, psychosis or agitation) often can be controlled effectively by psychotherapy and/or pharmacological means. When these symptoms are managed, individual patients may experience functional improvement, particularly in the early stages of this form of dementia.

The process of identifying neurobiological and neuropathological associations with Alzheimer's disease began to gather momentum during the late 1970s and has reached a fever pitch during the past five years. In that time, investigators have delineated more carefully the neuropathological and neurochemical deficits that result from the inevitable brain degeneration that occurs in this disorder. Not too long ago, it was impossible to study the Alzheimer's brain in living patients. Today, highly sophisticated studies, using equipment able to visualize the living brain, have allowed researchers to define the sites of defective physiological function.

Most important, a small, but growing group of scientists have been working to determine the genetic nature of familial Alzheimer's disease. At least two genetic (chromosomal) markers have been tied to the occurrence of Alzheimer's disease in specific target families. Although what has been identified are not the "Alzheimer's gene," their proximity to the defective gene sites provides substantial hope that investigators will soon move from the phase of association to discovery itself. Identification of specific genetic abnormalities may eventually allow scientists to develop specific therapies or cures. It is probable that there are several different kinds of biological defects that lead to the expression of this dementing disorder; ultimately, a distinct therapy may be developed for each defect. Work already is underway to develop specific medications that will delay or reverse the disease's progression and minimize its specific intellectual symptoms.

Delirium

Of the major mental disorders associated with aging, delirium is among the most poorly recognized, despite its frequency. Delirium is a disturbance of consciousness, typically reflected by an inability to focus or shift attention. Scientists have confirmed that delirium reflects a fundamental disorder of brain functioning. A patient with delirium often looks confused or intoxicated. Large numbers of older patients encountered in medical and surgical settings suffer from delirium; too often, delirious patients in nursing homes go unrecognized. The last decade has brought an increasing understanding of the impact of delirium on patients' future well-being. It is a powerful predictor of increased mortality among hospitalized individuals. However, it is one of the least well studied disorders, perhaps because it occurs in association with so many different diseases. Indeed, delirium is a final pathway through which many diseases express themselves. Discerning these underlying disorders and understanding how each leads to delirium, are central to the scientific challenge ahead.

Mood Disorders – Depression

Mood disorders are among the most common afflictions for individuals in all age groups in our society. However, with patients of increasing age, mental health professionals and primary care providers are confronted with an evolving clinical picture, in which mood disorders appear to manifest in a greater variety of forms. Thus, older individuals may have subtle disturbances, reflected in loss of energy, diminished interest, or withdrawal from social activities. At the same time, they may fail to express primary complaints of "sadness," "depression," or "feeling blue." Even when older adults exhibit the standard features of clinical depression found in younger individuals, recognition of mood disturbances are often confounded by the increasing occurrence of chronic medical illnesses and nagging physical limitations. Too often, clinicians will pass

off mood disorders as "understandable," in light of an older person's physical disabilities, even though available therapeutic tools could be used effectively to treat identified mood disorders. Thus, clinical recognition of depression and other mood disorders is often incomplete, even though the symptoms and problems are now well known.

As research has progressed through the recognition phase in the study of mood disorders, the association phase already has begun. In the past few years, research investigations have suggested that some older people with depression have definable abnormalities of sleep; recent work, using new neuroimaging methods to examine the living brain, has produced evidence of cerebral pathology. Careful clinical research points to the presence of previously undetected intellectual abnormalities. These, too, implicate a possible cerebral basis for the symptoms of depression and other mood disorders. For example, recent work investigating the occurrence of clinical depression among patients suffering from dementia suggests that mood disturbance is associated with the degeneration of very specific sites in the brain. In combination with new physiologically sensitive neuroimaging techniques, it may be possible to evaluate the cerebral effects of new, potent drugs on patients with severe clinical depression.

The elderly, like their younger counterparts, may also experience mood disorders that are not necessarily linked with brain degeneration, and can obtain relief from symptoms through psychotherapy and/or pharmacologic treatments. Recent research has shown that these therapies may be as effective in helping older adults as they are in aiding younger adults.

Psychosis

We are only beginning the quest to understand psychosis in the elderly population. Scientific inquiry has yet to establish whether late onset psychoses are simply the "tail-end" expression of primary psychiatric disorders that most commonly begin earlier in life, such as schizophrenia, or whether they are new and distinct entities, perhaps reflective of recently acquired brain disease. The greatest changes in the status of research into psychosis during the past few years have been the realization that psychosis in the elderly warrants specific study and a growing commitment by investigators to define its borders.

Conclusion

Much of the science of the aging brain and the disorders of that brain remains uncharted. Investigators have scant understanding of the evolving picture of mental disorders as patients age. This is especially true for conditions such as anxiety disorder, schizophrenia, and personality disorder -- problems that afflict many of all ages. Late onset psychiatric disorders, in particular, may prove to be secondary manifestations of a variety of cerebral or systemic medical diseases. Few have ventured yet in this direction, but exploration has begun.

New frontiers lay ahead in basic neurobiological and behavioral research in the quest to reveal the causes of brain aging, the mechanisms of neuron death, and the compensation mechanisms developed by the nervous system in response to these losses. Ultimately, investigators may discover methods to preserve or protect vulnerable nerve cells, or to promote more effective brain responses to damage. At the same time, scientists may discern the fundamental nature of mental alterations that appear to be an inevitable result of aging. Thus, it may be possible to overcome, or to minimize, the effects of forgetfulness, slowed thinking, or the diminished ability to develop novel strategies for solving problems.

Equally, future scientific inquiry will improve upon today's incomplete understanding of the complex relationships among physical health, mental well-being, and social factors such as life satisfaction and participation in day-to-day activities. Better recognition of these connections may help researchers and clinicians to develop strategies for both

maintaining health and promoting "successful aging."

Preventing the development of mental disorders in the elderly is the ultimate research goal. Investigations are underway to examine the clinical care needs of the elderly suffering from mental disorders, and to examine what therapeutic interventions and settings are the most efficacious. At the same time, scientists are beginning to study health maintenance and health promotion in an effort to maintain the mental health of those older persons who do not now suffer from mental disorders.

The causes of the majority of the mental disorders affecting the elderly are unknown at this time. As the population as a whole grows older, greater support will be needed to care for and treat people suffering from dementia, delirium, depression and psychosis. Investment in research now may ultimately save national resources; it clearly will improve the lives of future generations of older Americans and their families.

This fact sheet was developed under the general editorship of F.M. Baker, M.D., M.P.H. and Barry D. Lebowitz, Ph.D. The initial manuscript was written by Eric D. Caine, M.D. We wish to acknowledge the assistance of the following individuals who provided useful comments on drafts of this manuscript: Lissy F. Jarvik, M.D., Ph.D.; May Wykle, Ph.D., R.N., F.A.A.N.; and Theodora Fine, M.A.

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Mental Disorders of the Aging Research Branch
National Institute of Mental Health
5600 Fishers Lane, Room 7-103
Rockville, MD 20857

9/91

Ms. COLEMAN. I am going to invite our first panel to join us.

I have had the privilege, over the last few years of working with the Mental Health and Aging Coalition. The Coalition is a group of 35 national organizations, half of whom represent the concerns of the elderly, half of whom mental health issues. The Coalition and the Senate Aging Committee are cosponsoring today's forum. I would like to especially thank those who have made today possible. I would like to thank Holly Bode and Mia Masten from the Senate Aging Committee. I would especially like to thank Charlotte Mahoney and Ida Farlie who have been the staff support for this effort. AARP provides the Coalition with staff support and acts as the Secretariat. And I would like to thank the organizers, Katie Johnson from the National Association of State Units on Aging (NASUA) and Kathy Pontzer from the American Association of Family and Marriage Counseling who have represented this together. Other members of the Coalition have also helped and many are here today.

The Coalition's purpose is to provide opportunities for professionals, and consumers, and government organizations to work together toward improving the availability and quality of mental health, preventative and treatment strategies to older Americans and families through education, research, and increased public awareness. So it is to this end that we thought it important to do a public policy education effort. We have brought together those who have done research and those who have helped to formulate policy analysis and mental health and aging. We are fortunate and very thankful that not only Tipper Gore could join us today, but Bernie Arons, who has really been in the forefront of many of the issues that we will talk about today. Dr. Arons has been the lead person in the mental health group within the health care reform task-force at the White House.

As we identified experts and attempted to strategize about the goals for the forum it became clear that all mental health treatment is not biomedical, all mental health treatment is not psychosocial, but rather it was important to consider what the various disciplines had to offer. I was fortunate enough many years ago to work with Theresa Forster when I was on the Senate Special Committee on Aging. During that period I had a conversation with Senator Talmadge's staff. He was looking at the efficiency of mental health treatment for the elderly and came to me. He said, "Well, Nancy, is mental health treatment efficacious for older people?" I said, "Why do you want to know this?" He said, "Well, it is because Senator Matsunaga and Senator Inouye are interested in expanding Medicare to pay for mental health services. You know, I don't think any of that mental health junk is worth anything." It was at that time that Senator Church, the chair of the Senate Special Committee on Aging sponsored the hearings that Barry Lebowitz mentioned in his remarks. This committee and aging/mental health advocates began to do research and expand mental health services to the elderly.

Dr. Gene Cohen who has contributed so much to aging and mental health. It is a privilege to have him here today. For many of you who already know him, Dr. Cohen is both an M.D. and a Ph.D. and is the Deputy Director at NIA. He has in fact brought to those

of us in the policy arena and those of us in the aging community, geriatric health and mental health issues together. I think it is really quite amazing that he is both the editor-in-chief of the International Psycho-Geriatric Journal as well as the American Journal of Geriatric Psychiatry. His research is recognized throughout the world. It combines the study of the brain in addition to the study of the relationship of health and mental health.

Dr. Cohen will be followed by Dr. Marilyn Bonjean. She is representing the American Association of Family and Marriage Therapy today. She is a psychologist whose research is in chronic illness and clinical gerontology. She writes, she teaches, and she provides counseling services to older people.

Our third panelist this morning is Dr. Nancy Osgood who is a professor of gerontology and sociology at Virginia Commonwealth University. She has done research on suicide amongst the elderly and will talk to us about that issue today.

Dr. Cohen.

STATEMENT OF GENE COHEN, M.D., DEPUTY DIRECTOR, NATIONAL INSTITUTE ON AGING

Dr. COHEN. Thank you very much for your kind introduction. Mr. Chairman, Mrs. Gore, colleagues, it is a pleasure to be here and especially at such an exciting time, I think we are at an historic moment in the progress of research and developments in the aging field in general but especially in the area of mental health and aging.

Mrs. Gore actually introduced my first point by giving an illustration of what is possible with aging and advanced aging in the anecdote with George Burns. George Burns and I did a series of public service messages which I was delighted to hear just received a Gold Medal media award. In the slide the two of us are having a dialogue and I asked George Burns, I just have to say "What does your doctor advise you about your smoking and your drinking?" And he says, "My doctor is dead."

At age 97, he illustrates the capacity for wit and wisdom with aging. And that defines our challenge and our responsibility in the mental health and aging area.

The second slide is another very interesting one. It is the final painting by Grandma Moses when she was 101. This painting is very, very interesting not only in terms of its poignant visual imagery, but in its mental imagery as well. The title of this painting at 101 is "Rainbow." So I think again it reminds us as to the enormous potential for positive mental health and, again, defines our challenges and our responsibilities.

From a biomedical perspective, which is really the thrust of my presentation, I would like to emphasize what I believe is one of the most underappreciated major public health issues, and this too has already been introduced—that is, the adverse impact that mental health problems have on the course of physical illness and overall health in later life. In no age group is this interplay more dramatic than in older adults.

Now in addition to my work over the past 20 years with the Public Health Service, for the past 22 years I have continued my own community-based study based in a housing project of older adults;

I have followed almost all of them on home visits to intensively study the interplay of physical health, mental health, and social support systems. This dynamic interplay, involving the very profound effect of mental health factors in the course of overall health, is very dramatic with this group. What emerges is the enormous role that this has in influencing the course of these individuals and how often a change in mental health status becomes the key risk factor which increases the likelihood that person may need to enter a nursing home, or it influences their whole course in terms of long-term care.

The scientific literature is rich in studies that still, even though these studies have been published for over 10 years, get very little recognition and application. One very dramatic study showing the interplay of mental and physical health factors was done back in 1981, following patients age 65 and older admitted to the hospital with hip fracture. There were two groups that were set up, both with state-of-the-art treatment for hip fracture, but one of the groups additionally received mental health consultation during the course of hospitalization. The group that received mental health consultation in addition to the treatment for hip fracture had a reduced length of stay of 30 percent and twice as many in the group that received mental health consultation went home immediately following hospitalization. The other group that did not receive mental health consultation had a 30 percent longer length of stay and twice as many needed to go into a convalescent nursing home following hospitalization prior to returning home.

This was not an idiosyncratic study. The next year in the American Journal of Public Health a review of the literature found over 30 studies showing the same impact of mental health consultation on improved course of hospitalization. But still, this area is enormously underrecognized and its findings underapplied, the opportunity for mental health interventions to improve the course of overall health is enormous.

If you look at a number of major brittle or fragile general medical problems, you can get a better understanding as to how mental health changes can affect their course. If somebody has a serious cardiac arrhythmia delicately controlled with medication, any problem that will interfere with their mental status—it doesn't have to be Alzheimer's disease, it can be depression, it can be anxiety, it can be schizophrenia—is going to compromise their ability to stay focused on their own medical and medication management. The same will apply with diabetes. So people with these chronic, very delicate general medical problems, in the face of mental health problems, can quickly get into serious problems, again highlighting the importance to pay attention and address mental health problems.

And then more recently the focus on older caregivers of Alzheimer's patients has again illustrated the impact of stress on overall physical functioning, where these older caregivers of Alzheimer's patients, as a factor of prolonged stress, have demonstrated changes in their immune system. These caregivers have also revealed increased frequencies of physical illness, increased numbers of doctor visits, increased medication usage, resulting in increased overall medical costs. Caregivers of Alzheimer's patients

represent the second patients in Alzheimer's disease—those with prolonged stress and depression in the course of caregiving.

I would like to conclude by reminding everybody that the efficacy of mental health interventions, our knowledge of this, is not new. We have in effect known for 150 years about the efficacy of mental health interventions. This is based on the famous case from London in 1843. We now have the 150th anniversary of this case, where the efficacy of mental health interventions was so apparent that we have now for the past 150 years in Western societies celebrated this case every Christmas. This is the case of a famous figure in London in 1843 who was described as "a mean spirited, misanthropic individual who made the lives of everybody around him very miserable." As the decades went by, what people had overlooked was the underlying diagnosis of a chronic depression. Finally, in his later years he was the beneficiary of an enlightened very au courant outreach oriented, crisis oriented team who visited him on a home visit and applied dream work 50 years before Freud's classic work on the interpretation of dreams and turned things around for this individual. This of course was the case history of Ebenezer Scrooge.

It really illustrates the rest of the story of "A Christmas Carol" and the real reasons why Dickens wrote "A Christmas Carol." Dickens wrote "A Christmas Carol" for four reasons. First of all, he wanted to illustrate the atypical course of depression with aging. Second, Dickens wrote "A Christmas Carol" to illustrate the efficacy of treatment for older adults independent of age. Third, he wanted to illustrate the value of psychotherapy including the use of dream work in treating depression in later life. And fourth, he wanted to illustrate when you help the elderly this results in benefits to society as a whole, witness the benefits to London, Bob Cratchit and Tiny Tim. That is the real reason that Dickens wrote "A Christmas Carol" and why we celebrate it every Christmas—a celebration of the efficacy of mental health interventions for the past 150 years.

I hope at this point we can gear up to the tremendous challenges and opportunities in the late 20th century and bring research and policy in the area of mental health and aging to a whole new level. I am very excited about it and I am confident that we can do that.

Thank you very much.

[The prepared statement of Dr. Cohen follows:]

Gene D. Cohen, M.D., Ph.D.

The Impact of Mental Health Services on Physical Health and Independence Among the Elderly

Recently I met with the comedian George Burns, now 97 years old, to do a series of public service announcements for television. He had his characteristic cigar in hand, so I asked him what his doctor had to say about smoking and drinking. "My doctor's dead," he replied.

The PSA won a Gold Medal Media Award. But that succinct answer did more than make a funny and attention-getting PSA. It also illustrated the capacity for wit and wisdom with increasing age. And it is this capacity that defines our challenge and responsibility in the field of mental health and aging. The potential for mental health in old age, even mental growth and development, is real. Consider Grandma Moses, whose final painting at age 101, "Rainbow," is full of poignant visual and mental imagery.

From a biomedical perspective I would like to emphasize what I believe is one of the *most under-appreciated major public health issues* of our time, i.e., the adverse impact of mental health problems on the course of overall health and physical illness in later life. For the past 22 years I have been conducting a community-based longitudinal study of older adults with mental health problems living independently in the community (In addition to my work in the Public Health Service). I see nearly all of these people on home visits, studying the interplay of mental health, physical health, and social supports. I have found that the role of mental health is absolutely profound--often the critical factor influencing the need or timing of nursing home placement, apart from the magnitude of long-term care in general.

The scientific literature is rich in studies that have not yet been recognized or applied as they should. One very dramatic study (Levitan and Kornfeld, 1981) followed two groups of patients age 65 and older who had been admitted to the hospital with hip fracture. Both groups received state-of-the-art treatment for hip fracture, but one of the groups also received mental health consultation while in the hospital. The group that received consultation had hospital stays 30 percent shorter than the group that received no consultation Moreover, twice as many people in the first group were able to return home immediately following hospitalization rather than go temporarily into a convalescent nursing home.

The year after this study appeared, a review of the literature found over 30 studies demonstrating that mental health consultation had a similar impact on the course of hospitalization (Mumford et al., 1982). Nevertheless, the influence of mental health on physical health receives little recognition; the findings of these studies are rarely applied.

Mental health and physical health can interact in various ways. Consider the following four paradigms:

Severe psychological stress can have physical health consequences. One excellent example is the relationship between anxiety and gastrointestinal (GI) symptoms. The accurate diagnosis of gastrointestinal symptoms can be very difficult in the elderly, with research showing that as many as five out of nine older persons with GI trouble may be experiencing psychological problems that lead to their physical discomfort.

We have also seen the impact of prolonged stress in the case of older caregivers of Alzheimer patients. These older caregivers become the hidden second victim in Alzheimer's disease, with studies revealing

- compromised immune system functioning;
- increased physical illness;
- increased doctor visits;
- increased medication usage; and
- increased overall medical costs in these caregivers.

Physical disorders can lead to psychiatric disturbance. Hearing loss, for example, can lead to onset of delusions. Approximately 30 percent of the elderly have hearing impairments. In certain vulnerable individuals, a resultant sensory deprivation phenomenon may be at work in the development of psychotic symptoms.

Coexisting physical and mental disorders can exacerbate each other.
Anything that interferes with mental status can compromise an older person's ability to manage a medical condition. The mental health problem need not be a dementing disorder like Alzheimer's disease; depression and anxiety as well as schizophrenia in later life, or other factors interfering with mental status, will compromise an older patient's ability to manage his or her medications.

The potential interplay between depression and cardiac disorder, two of the most common health problems of the elderly, provides an example. A covert depression could be bring about indirect suicidal behavior acted out by failure on the part of the patient to follow a proper schedule of medication; the resulting clinical picture could then be one of further deterioration in overall cardiac capacity, due not primarily to physical factors, but to psychosocial ones.

Psychosocial factors can affect the clinical course of physical health problems.
Adequate social supports to help with proper medical management and follow-up are important in determining the course of some chronic illnesses, especially those that are delicately controlled, such as cardiac arrhythmia or diabetes. Diabetes, for example, has a number of complications that can be prevented or retarded with careful management. A person with diabetes living in isolation could be at increased risk of losing a foot or developing other complications in the absence of social support to help manage the condition. (In the United States, more than one in three older women and one in seven older men live alone.)

Such paradigms are important for they help facilitate a multifactorial problem oriented approach to diagnosis and treatment planning that is both appropriate and essential for the older patient. They reflect the growing state-of-the-art in the field of mental health and aging and the contribution of this body of knowledge to meeting the needs of the "whole" patient as he or she ages.

Finally, it should be noted that we have known about the efficacy of mental health interventions in the elderly for many years. For the past 150 years, in fact, western societies have celebrated the efficacy of psychotherapy for older adults every Christmas. This celebration is based on the outcome of the famous case from London in the year 1843--the case of a well known London figure who, over a period of decades, had a misdiagnosed case of depression. The depression was cured following an enlightened mental health outreach effort, which involved a team approach and the psychodynamic use of dreamwork.

In his write-up of the case of Ebenezer Scrooge, Charles Dickens illustrates:

- the atypical course of depression with aging;
- treatment that is effective independent of age;
- the value of psychotherapy, including dreamwork in later life; and
- that when you help the elderly, the community at large benefits (witness Bob Cratchit, Tiny Tim, and others whom Scrooge ended up helping).

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Ms. COLEMAN. Thank you, Dr. Cohen.

We have the privilege of having Senator Paul Wellstone join us. If he would like to make some remarks at this point, we would welcome those.

STATEMENT OF SENATOR PAUL WELLSTONE

Senator WELLSTONE. Thank you, Nancy. I actually don't want to interrupt the flow of some important discussion. I would like to thank Senator Pryor for convening this and I would certainly like to thank Tipper Gore and Bernie and others for just all of your work.

I just will say two things. I came in in the middle of this and I apologize. It is one of those days where two or three things are going on at the same time and I have to go to another committee hearing. I feel like this gathering is very important. I think, and I don't believe I am being melodramatic, that this is a very historic period of time because we have the opportunity, the possibility of finally making sure that comprehensive and flexible mental health benefits, for people, for men and women, regardless of age, including the elderly, are no longer put in parentheses or brackets but become a part of what we view as affordable, dignified, humane health care in the United States of America. I feel very strongly about that. I come from a family where I saw my brother struggle with this most of his life. Both my mom and dad, Tipper, had Parkinson's, it is kind of unusual that both had Parkinson's. My mom also had Alzheimer's. Sheila and I and our children all went through that with them. And so all the issues that you talk about are near and dear, they are not just intellectual or abstract. I hope that Mrs. Clinton and the task force and the President will really present some important proposals. I know Tipper Gore is in there pushing so hard for this. I am completely dedicated to this and our office intends to be just as strong as possible an advocate for really good mental health and substance abuse benefits for people.

I am just in and out but I just came here to say you are not out of sight or out of mind. I really appreciate the work of all of you.

STATEMENT OF MARILYN J. BONJEAN, ICF CONSULTANTS, INC., MILWAUKEE, WI

Ms. BONJEAN. As someone who works with families often, one of the reasons that I really enjoyed being invited here today, Madam Chairman, Mrs. Gore, and colleagues, is to talk about their needs. We all now have the opportunity to live in four and five generation families. We will get the opportunity to appreciate the rich heritage, knowledge, wisdom, and example that the elders that we're related to and that relate to us in our families and communities can bring to us. I certainly experienced this personally. I have always lived in a four generation family; I have had that wonderful opportunity. One of my grandmothers is still living. She lives in a small town in Iowa with my parents. So when I think about mental health issues, I am concerned about mental health issues in a relational context. There have already been remarks that remind us that as we age we need to look forward to mental health.

Mental health is more than just the absence of illness, it means a lot more than that. We need to think about the idea of positive

behaviors in our relationships, about having a subjective sense of well-being, about the idea of growth and self-actualization, autonomy, and mastery over our environment so that we can look forward to something really positive as we age. Fortunately a majority of older people reside in very good mental health. So, again, that reminds us of how important it is that when mental health problems arise, we recognize them as promptly as possible because then the treatment is easier and people can partake of some of the efficacious treatment that we now have available.

It is important for us to remind ourselves that mental health exists in a context. It exists in the context of my family and some of your families and in the society in which we all reside. I would like us to think together about some of the components of that context. One component of the context of mental health and mental health problems is that we all live in the same society and in our society there are some pervasive myths about what it means to get old. Some of those myths create problems in recognizing the need for treatment. We all subscribe to some of these myths. For example, we have a myth about memory loss being normal in late life so that if older adults begin to feel some changes in memory they may write them off as normal aging, not report them and not begin to enter into a treatment process. And you and I do that too when we lay down our papers, we walk away, we can't remember where they are, and we say "Oh, I forgot that. I guess I am getting old." So we all sort of expect some of these things and it leads to not recognizing a need for treatment.

We also see changes in sleep patterns with aging. Some of those are normal and some of them really are not. If older persons go to a physician and report sleep problems, they may very well be told "Oh, well, you're getting older. Maybe you don't need as much. That's a pretty normal change." When actually it may be one of the many signs of an initial depression which would certainly be alleviated by treatment if it were recognized. Or diminished sexual interest. We have a pervasive myth in our culture that older adults are asexual. Well, I will ask you all a question: When do you decide to give up your sexual interests? And if you don't decide to give yours up at anyplace in your lifetime, then perhaps that is also true for all the older adults with which we come into acquaintance. If an older adult comes into a professional's office and reports diminished sexual interest, that may very well be ignored as a part of the aging process when actually it may be part of a disease process, one that can be alleviated with treatment.

Mental health issues occur in the context of certain kinds of problems that are more prevalent when we age, and we have heard a little bit about some of those. For example, Alzheimer's disease, one of the organic illnesses, becomes more prevalent as we age. When someone has Alzheimer's disease certainly that doesn't just affect them, it affects the whole ecology of their life. It especially affects at least one other person who is helping them and becoming their caregiver. I became very in touch with this when my mother-in-law had Alzheimer's disease for about 15 to 20 years. In a very traditional Italian family, which is my husband's, we really struggled with being able to provide care for her and allow other people to come in and help us with that care.

We have also heard about the prevalence of depression. Usually depression isn't something that affects only one person. If I live in a family and I become depressed, that depression affects my whole context. Certainly we know that Scrooge's depression affected a lot of people around him. When we think about the efficacy of treatment, we want to think about it in a relational context.

We have also heard about the co-occurrence of physical illness so that we know mental health problems occur in the context of an aging body. What is happening to us physically certainly has an effect on our mental health. We need well-trained professionals so that when someone comes reflecting a physical problem there is also an opportunity to talk about what may be happening in terms of mental health. We can treat the whole person at one time and coordinate our mental and physical health referrals so that we aren't trying to be everything to everybody but are really focusing a team effort for treating the co-occurrence of physical health and mental health needs.

I know as a family therapist that mental health problems occur in familial contexts. When there is a physical health problem, the first person that older adults turn to is a family member—80 to 90 percent of the care that older adults receive comes from their families. My grandmother would not be able to live in her own home without my parent's help. Without that help she would now be in a nursing home. Many families across the country are helping their older adults to remain independent and in the community. But when we design treatment, we often think about it as an individual issue instead of a contextual issue. We must invite families into opportunities to cooperate and put together care plans which are going to be helpful in delivering treatment to older adults since families are certainly inherently involved in providing the care. We as professionals need to be providing a context in which they can participate.

Part of the context of providing mental health treatment and dealing with mental health issues is a racial and an ethnic context. We know really very little so far about the context in which some of the mental health problems occur for minorities. I think that we need to be doing a lot more to look at the issues, wishes for treatment and design of treatment for racial and ethnic minorities. One of the things that we do know is that across the board we have dedicated families with whom people are living and who are providing a great deal of their care.

Gender is another issue that comes to light when we think about the context of mental health. There are separate gender issues. If I am an older white male, then I am at high risk of suicide. But if I am an older woman, then we women outlive you men and so you become ill, we take care of you, you die, and then we're left alone. When I am teaching my gerontology classes, I say to the girls "Marry very young men."

A gender issue for women is widowhood which puts us at more risk of depression. We see that it just gets worse as we age because over 85 we have about a 2 to 1 ratio of women to men. Early in the next century we're going to have about a 3 to 1 ratio. We want to provide treatment in a gender sensitive manner.

Mental health issues, must be considered in terms of relationships, the ecology in which mental health issues occur. If we can think about it in that way, then another thing that I say to my gerontology classes is "I can relax." I can become comfortable as I look forward to well-trained professionals who when I have an issue or a problem are not going to treat me as though I am a disembodied spirit. They are going to think of me as both mind and body, as part of my family and part of my community. So another reason I am here is to selfishly advocate for myself and perhaps some of you as well who want to look forward to very good care as we age.

[Applause.]

[The prepared statement of Ms. Bonjean follows:]

MENTAL HEALTH AND AGING BRIEFING - JULY, 1993

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MENTAL HEALTH AND AGING - OLDER ADULTS IN RELATIONAL CONTEXT

Life expectancy is increasing for humankind and bringing with it both blessings and challenges. The four and five generation family is becoming normative, making the wisdom, example and support of older members available to those who are younger. I have always lived in a four generation family. Knowing my grandparents allowed me and my children to experience past historical periods through their eyes, become deeply rooted in my Norwegian heritage and receive a legacy of values gleaned from their life experiences. It also provided a witness to family solidarity in the face of illness and death.

Maintaining mental health as we age is essential if the opportunities for intergenerational exchange and societal contributions of talent and wisdom are to take place. Our society is challenged to provide the support older adults need to sustain mental and physical health which are closely intertwined in later life. Mental health means more than the absence of pathology. It implies in addition that the individual behaves in positive ways, has a subjective sense of well-being, growth and self-actualization, autonomy and environmental mastery so that each person can make a unique contribution to our species.

Mental health is clearly central to insuring the total well being of older adults. Fortunately a majority of those over 65 are in good mental health cognitively, emotionally, behaviorally and spiritually. The fact that mental health is the norm for this final third of life, points to the importance of promptly recognizing and effectively treating mental health problems. Symptoms of mental illness in later life are often overlooked as inevitable in the aging process due to various myths and stereotypes about aging. Older adults, families and professionals need education regarding myths which perpetuate mental illness. Due to myths of memory loss in aging, intellectual difficulties can be dismissed as normal aging rather than initiating an assessment. Sleep changes can also be ignored rather than evaluated to

rule out depression or other disorders. Diminished sexual interest or capacity may be disregarded if older adults are believed to become asexual and important aspects of close relationships may suffer. Lack of treatment has serious effects for older adults, their families and the surrounding society. Failure to diagnose and appropriately treat mental illness limits elders contributions of wisdom and talent, perpetuates stereotypes, exacerbates physical illness, burdens spouses and families with excess disability, and endangers independent community living.

EPIDEMIOLOGY OF MENTAL ILLNESS IN THE ELDERLY

When it occurs, mental illness in late life is significant in its influence on personal well-being, supportive relationships, and physical health. The following is an overview of the major challenges to mental health in late life:

ORGANIC MENTAL DISORDERS affect more than 6 percent of older adults. These include Alzheimer's disease, multi-infarct dementia and delirium. Alzheimer's disease (AD) is a prevalent disorder which affects as many as 4 million Americans. Because the "oldest old" are both the fastest growing segment of society and at the greatest risk of developing AD, projections suggest that the number of AD patients will rise to over 6 million by 2040. The National Institutes of Health and Consensus Development Conference Statement on the Different Diagnosis of Dementing Diseases (U.S. Department of Health and Human Services, 1987) emphasized that dementia is primarily a behavioral diagnosis. Since most of the symptoms for much of its clinical course are behavioral, mental health intervention is critical for the patient and family caretakers. Learning to manage constant questions, poor judgement, wandering and combativeness are just a few of the challenges for caretakers. Coaching in behavior management can help caregivers maintain patients at home through out much of the disease course. Psychotherapy for the caregiver can aid in accepting community services and balancing the conflicting feelings of emotionally losing a family member who remains physically present.

DEPRESSIVE SYMPTOMATOLOGY has been described in as much as 15 percent of community residents over 65. According to the Epidemiologic Catchment Area Study, the rates of major or minor depression among elderly people range from 5 percent in primary care clinics to 15 to 25 percent in nursing homes. The rates of new cases of depression in nursing homes are striking: 13 percent of residents develop a new episode of major depression over a 1 year period. There is a sharp drop in the rates of treatment of depression among the elderly compared with younger adults. By one estimate only about 10 percent of the elderly who are in need of psychiatric treatment ever receive this service.(Reiger et al., 1988). The major social and demographic risk factors for depression in the elderly are generally similar to those of younger age groups: women, the unmarried, widowed, those with stressful life events, and those who lack a supportive social network. In older people the co-occurrence of physical conditions such as stroke, Alzheimer's disease, or cancer and depression has been confirmed. Depression may also enhance vulnerability to certain illnesses, particularly of the immune system.

SUICIDE rates are higher among the elderly with depression compared with their nondepressed counterparts. Although suicide rates in the general population were 12.4 per 100,000, rates in 80-84 year olds were 26.5 per 100,000. Elderly white men are at highest risk (Koenig, H. and Blazer, D., 1988). More than three-fourths of these persons had visited a primary care physician within the month before their suicide yet their symptoms of depression went unrecognized (Rabins,P., 1992). The families of suicidal older adults are often involved in their treatment since the family may be the most sensitive to shifts in mood and behavior. Family therapy is imperative for recovery so that the older adult can find the role and meaning in life to continue to cope with stressors which precipitated the suicide attempt and family members can learn appropriate methods of communication with a severely depressed elder.

ANXIETY DISORDERS are twice as prevalent as depression in late life but have received much less study (Regier et al., 1988). These disorders consist of such diagnoses as phobias, obsessive-compulsive disorder, post-traumatic stress disorder and generalized anxiety disorder. Most of the time anxiety is part of a more complicated set of interactive circumstances which respond well to a combination of psychotherapy and pharmacotherapy (Gurian, B. and Goisman, R.,1993).

THE INFLUENCE OF SOCIAL SUPPORT ON MENTAL HEALTH

Social support is paramount to the mental health of older adults. Those who are part of a supportive network are less likely to be depressed especially when faced with illness and limitations. Affective support from spouses, friends and confidants emerges as a primary mediator of stress. The family is a major resource in the care of older geriatric patients and a key component in planning their care which could include community based care such as activity centers, day care, congregate meals, assisted housing, respite care, and psychotherapy as well as institutional services in hospitals and nursing homes.

Four areas of mental health need are expressed by older adults within a family milieu: 1. to sense belonging; 2. to integrate past, present and future life experience; 3. to adapt or adjust to changing demands from both internal and external sources; and 4. to be supported in managing final life transitions in preparation for death (Eyde,R.and Rich,J., 1983, p11.). The family has been the primary and preferred social institution to deal with physical, social, and economic problems of older adult members (Benston and Treas, 1980, p 400). Despite the stresses and demands upon emotional and economic resources the majority of frail elders are living in their own homes or with family members. Impaired elderly tend to avoid seeking help outside the family and the nature of mental illness often interferes with help seeking. Consequently family members often serve in a referral capacity and are part of initiating and carrying out care plans with service providers. Families define the context of psychological distress, such as onset, course, and duration. They know what is normal and not normal for their members and they help members identify stress realistically and seek appropriate, timely help. Families appreciate the continuity of older adult's lives, have a sense of their history, can create a motivation for change and initiate different behavior. Except for individuals who are extremely impaired it is more cost effective to maintain older adults in the community with a coordinated package of services than institutionalize them.

Providing this care is not without cost to family members. Those caring for the most frail report very high rates of guilt, demoralization and depression. Caregivers also show significant suppression of a number of immmune system parameters, thus making them more susceptible to illness and death from various infections or influenza. Therefore family members must be involved in treatment which affects the whole relational system in which the older adult lives. Providing attention to and treatment for the natural ecology of mental disorders in the

aged including family influence on mental health is critical to the patient's emotional state and experience of emotional disturbance. The family context can offer the patient tremendous reassurance or can add immensely to emotional distress. In some cases, family conflicts can be important in the genesis of the disorder itself.

Conclusion

Professionals who are well educated in focusing the self-healing capacities of families on the mental health problems of older adults will be needed in increasing numbers. The American Association for Marriage and Family Therapy (AAMFT), the only national accrediting body for family therapists, has offered an interest group for gerontological family therapists over the past ten years. This group has provided education for members and advocated for the mental health needs of elders and their families. The first training grant to a master's level program in marriage and family therapy to train students to work with severe mental illness in the elderly, and research the disorders, was given to the University of Rhode Island. In 1992, the marriage and family therapy program, accredited by the Commission on Accreditation for Marriage and Family Therapy Education, was awarded a grant by the National Institute of Mental Health. In 1991, Kansas State University was the first doctoral marriage and family therapy program to receive such a grant (Botsford, A., 1993). Through supporting members interest in serving older adults and their families, AAMFT will continue to prepare professionals for the growing field of clinical gerontology.

A focus on the positive contributions of older adults to society and their capacity for creative change will create an ever increasing demand for treatment of mental disorders in the aged. Families will no longer accept myths about aging which limit the capacity of their members to positively relate to each other. Development of a comprehensive model that organizes biopsychosocial variables and subsequently translates this information in a utilitarian form to elders and their families is our challenge.

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Mrs. GORE. I just want to say goodbye because I need to leave to go on to another appointment. I have learned already a great deal and will continue to be in touch with all of you as we fight to push forward this agenda and end discrimination about mental health care for people of all ages. Thank you.

[Applause.]

STATEMENT OF NANCY OSGOOD, DEPARTMENT OF GERONTOLOGY, VIRGINIA COMMONWEALTH UNIVERSITY AT RICHMOND

Dr. OSGOOD. Members of the audience and members of the Committee, I consider it a real privilege to be able to be here to talk about the important topic of elderly suicide as one of the major mental health issues and public health problems facing the elderly today in the United States.

By the time I am finished speaking, and we eat lunch at roughly 12:30, another person 65 and older will commit suicide. About every hour and a half someone 65 and older in this country commits suicide. That is 17 people every day. An earlier speaker mentioned that 8,000 people turn 65 every day. Well, 17 of them take their lives that same day. Last year, roughly 7,000 older adults committed suicide, which is a very large number. We have roughly 32 million older adults in our population.

Suicide is the 13th leading cause of death for the elderly, which sounds fairly low. But, there are so many causes of death in the elderly—the flu, a cold, heat exhaustion, nearly 100 deaths in Philadelphia—that the fact that suicide is the 13th cause is fairly serious. What is even more serious is that suicide is the leading cause of unnecessary death and the most preventable cause of death in older adults.

If we look at suicide rates, we see that attention has generally been focused on youth and young people. Until the last decade, most of the research and media attention was focused on the teenage suicide rate. I think that teenage suicide is an important problem. But the fact is that the suicide rate is actually the highest for the elderly. Those 65 and over have a 50 percent higher suicide rate than teenagers. The rate of suicide for the elderly is also 50 percent higher than the rate of suicide in the general population. Those 65-plus have a rate of about 22 per 100,000; and the suicide rate for teenagers in the 15- to 24-year-old age group is approximately 13 per 100,000. The rate for the U.S. population as a whole is also approximately 13 per 100,000.

The rate of suicide among the elderly increased in the period 1980 to 1988. There has been a very slight decrease between 1988 and 1992. But between 1980 and 1988, the rate of elderly suicide increased 25 percent, while the numbers of older adults choosing to take their lives in that period increased 40 percent. At the same time, the suicide rate for the general population and the suicide rate for teenagers stayed virtually the same. So the elderly are a particularly vulnerable group. I like to attribute the slight decrease in the suicide rate of the elderly between 1988 and 1992 to our efforts in the mental health field and the mental health treatment field.

There are several reasons that have been given to speculate on why the rate increased so much during that time period. If there are any Democrats here, one of the speculations is that during the era of Reaganomics there was a lot of belt tightening and a lot of changes economically speaking which may have hurt the depressed, lonely, isolated, vulnerable elderly living at home. So there is the economic explanation during those Reagan years.

I think another appropriate explanation is the fact that in recent years we are more accepting of suicide in this country. Witness the growth in the Hemlock Society and the popularity, of *Final Exit,* Derrick Humphrey's book that tells people exactly how to commit suicide without fail. The media presentations often justify suicide; and the jargon, which calls for the "right to die," the right to "self-determination," and "death with dignity" cast suicide in a more positive light. Most of the people who die are elderly. So all of those cries are pertaining particularly to older adults. We are not really seeing rallying cries for the right to suicide among teenagers in the United States or even the right to die among teenagers. Our climate of acceptance of suicide holds true more for older adults.

Another explanation offered for the increase is that we have had an advance in medical technology, and that could be a double-edged sword. If you have a larger quantity of life without increasing quality, then it is not necessarily a good life and people may choose to end that life.

I want to point out that some people are more vulnerable in later life to suicide than others. Males are much more vulnerable to suicide in late life than females. In fact, for those 85 and older, males are 12 times more likely to kill themselves than females. In terms of racial differences, elderly whites, especially white males, are a particularly high risk group and have very high rates of suicides. The minorities differ; the rate is lower in Afro-American elders but higher in older Asian-Americans. The old-old have a rate that is higher than the young-old, the 75-plus group and the 85-plus group are more vulnerable than the 60 to 65 or 65- to 74-year-old age group.

What is the future outlook for suicide among the elderly? I think we have to be a forward looking country. In terms of making policy, we have to consider what the future might look like. We have seen a dramatic growth in the older population since 1900 from roughly 3 million elders to 32 million today; and the prediction is that there will be 52 million older adults in the year 2020 or 2030 when the baby boomers start to enter the ranks of the elderly and begin aging. What that means is that even if we do not experience an increase in the rate of suicide and it stays exactly the same as it is today, we will still see almost a doubling in the numbers of older people who take their own lives because there will be so many more older people. So if the rate stays the same, the number of elderly suicides will double. By the year 2020 one older person could commit suicide every 45 minutes in this country—35 older people commiting suicide every day and 14,000 taking their lives every year.

So I think the future outlook, unless we do something in terms of treatment and recognition and education, is not very promising.

I am glad to see the attention devoted to suicide on this particular committee.

Two of the major factors in elderly suicide are depression and alcoholism. Depression, alcoholism, and suicide form a deadly triangle. At the top of the triangle is suicide and then on the two corners are alcoholism and depression. Older adults who are alcoholic are much more likely to commit suicide than the nonalcoholic elders. Similarly, those who are depressed, suffering from either clinical symptoms of depression or clinically depressed on DSM3R criteria and other criteria, are much more likely to commit suicide than those who are not depressed. There is a large body of research literature to support these relationships.

So what can we do about this problem and how can we prevent elderly suicide? I want to offer two or three suggestions. I have a lot of suggestions but not a lot of time.

The first thing I would suggest we need to do is make an effort to educate people about the signs and symptoms of elderly suicide, the signs and symptoms of depression and alcoholism. We need a massive education effort so older people themselves can recognize when they are depressed or abusing substances or are suicidal and so that these problems can be recognized by physicians, nurses, public health workers, and mental health and aging workers.

I think we also need to educate about what is available to treat older people who are suffering from suicidal thoughts and ideation in their communities. The Gallup Poll on elderly suicide, the results were released last December in New York, found that most physicians never ask about suicide when the people go to the doctor and also found that 75 percent of the elderly surveyed, a large number of elderly picked at random in the country, did not know of any services in their community that could help if they were suicidal or they had a suicidal friend. Only 25 percent said, yes, there is something in my community and I could tell the people where it is if they needed it. So I think we need not only education, but we also need services and education about what services to help suicidal elders are available.

We also need active outreach and aggressive casefinding because the research is clear that older adults do not walk into mental health centers, they do not call crisis hot lines. Less than 2 percent of the calls to crisis hot lines come from the elderly; they come by and large from younger individuals. So we are going to have to find the older adults who are lonely, isolated, depressed, alcoholic, or suicidal. We could possibly do that through pharmacists, local community physicians, churches and community groups where elders attend, or through other older individuals who might identify depressed and suicidal relatives and friends. But we certainly need active outreach.

I would argue we need a variety of other services. For example, pain clinics, good palliative care for people who are suffering from chronic illnesses and terminal illnesses that might occasion pain; geriatric mental health services that are age appropriate, especially for treating alcoholism, because the research suggests that age appropriate services are much more effective than mixed age services; widow-to-widow programs, pre-retirement counseling, and a lot of other psychosocial services are needed as well. I think if we can

take some of these steps that we can possibly prevent the drastic increase in the rate of elderly suicide and the numbers of elderly suicide in the future. I would urge that we take these steps now.

[The prepared statement of Dr. Osgood follows:]

Backgrounder

SUICIDE BY THE ELDERLY

- Older people (65+) make up the age group at highest risk for suicide. While they represent 12.5% of the total population, they commit 21% of all suicides. (1990 Census)
- The 1990 Census also reports that 30,906 people died by suicide; 6,394 were 65+. Some leading suicidologists expect the numbers to double by the year 2030.
- There is one elder suicide every eighty-two minutes; seventeen each day.
- Older white males are at greatest risk for suicide. The risk increases with age.
- The ratio of attempts to completed suicides is 100-200:1 for young people, but 4:1 for older persons. Reasons for their success include more lethal methods, greater motivation to die, poorer recuperative powers, and social isolation. (American Association of Suicidology)
- The causative factors for elder suicide include:
  - Depression
  - Alcoholism
  - Losses (loved ones, self-identity after retirement, financial security, health, safety, independence)
  - Social isolation
  - Ageism
  - Poor coping mechanisms
- While depression, a major cause of suicide, has an 80% successful treatment rate, the elderly tend not to seek mental health help.
- A study of all 1990 elder suicides in Cook County, IL, reported that 20% had seen their doctor within twenty-four hours of their suicide, 41% within seven days, and 84% within thirty days. 63% were not severely ill. (Clark Study)
- It is estimated that every suicide affects at least six other people. (Dr. E. S. Shneidman)

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Myths and Realities

Myth: People who talk about suicide rarely do it.
Reality: Eight out of ten suicides spoke about their intent before the suicide.

Myth: More people kill themselves during the holiday season than at any other time.
Reality: There are only minor differences in the suicide rates each month. However, the rates rise slightly in the spring (April-May).

Myth: Asking someone if they are contemplating suicide increases the risk of suicide.
Reality: Asking direct questions about suicidal intent does not encourage suicide. The risk is in not asking questions to identify suicide potential.

Undetected Depression

The wide range of estimates available on the incidence of depression among mid-life and older adults attests to the difficulty of diagnosing the illness in the older population. Many family physicians may be unfamiliar with the symptoms of depression in later life, or may not diagnose the illness because its symptoms can be masked by other physical problems. Family or friends often mistake depressive symptoms as the everyday problems of the older adult, or misconstrue the signs as the onset of senility. In addition, many older people rarely admit feelings of depression and may attribute their symptoms to physical ailments.

Clues to Suicidal Behavior (Multiple clues are indicative of potential suicide):

- An overwhelming sense of hopelessness and helplessness
- Withdrawal from usually pleasurable activities
- Signs of frequent drinking (alcohol on breath, frequent falls)
- Exaggerated physical complaints (aches, pains, etc.)
- Changes in weight, appetite, sleeping patterns
- Feelings of worthlessness, guilt, fatigue, low self-esteem
- Difficulty thinking or concentrating
- Purchase of a firearm
- Neglecting self, home, finances, pets
- Verbal statements suggesting a desire to die
- Socially isolated; may be self-imposed isolation
- Family or personal history of suicide attempts

How to Help a Suicidal Person

- **Depressed persons need to be referred for professional help!** Depression is treatable.
- Do not ignore the threats of suicide. It is helpful, not intrusive, to ask:
  - Are you thinking about suicide?
  - How would you do it?
  - Where are you going to do it?
  - Do you have the means available? (gun, pills, etc.)
  - Have you stopped taking your medications?
- If the person can answer these questions, the danger of suicide is real. Get help immediately through a local suicide hot-line, family physician, hospital psychiatric unit, hospital emergency room, family members, or police department.
- If the person does not have a suicide plan (cannot answer questions above), there is generally time to find a mental health professional through the family physician.
- Pay attention; encourage them to talk; listen; be, and stay, involved. Letting someone freely discuss their thoughts shows you care and may reduce the emotional pain causing suicide.

Recommended Resources and Reading

- American Association of Suicidology
  2459 South Ash
  Denver, CO 80222
  (303) 692-0985

  American Suicide Foundation
  1045 Park Avenue
  New York, NY 10028
  (212) 410-1111
- "Suicide in Later Life—Recognizing the Warning Signs", Nancy Osgood, Lexington Books, NY, 1992.
- "Suicide and Life-Threatening Behavior", Vol. 22, No.1, Spring 1992, American Association of Suicidology, NY.
- Free brochures on the depression of older persons are available to the public by writing AARP/SOS, Dept. D, 601 E Street, NW, Washington, DC 20049.

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LARRY RICKARDS, CO-MODERATOR OF FORUM

Mr. RICKARDS. I want to thank Dr. Cohen and Dr. Osgood and Dr. Bonjean for their excellent statements and being able to highlight some of the key issues. Unfortunately, we don't have time for many questions, but being that I have the microphone I have the opportunity to pose one.

We have talked about the service needs of older persons often without a context of where we are with regard to treating older persons. How many older persons are being treated for mental health services within our various mental health systems? Any estimation? What are some of the major barriers to service provision?

Dr. COHEN. I am under the general impression that we probably have at least 75 percent of the group in need of care who are not receiving it. That may be a liberal estimate; there may be significantly more than 75 percent who need help who aren't getting appropriate services.

Mr. RICKARDS. So a large gap between what is needed and what is delivered to this population.

Mr. LEBOWITZ. The issue here is of course not that they are not getting any service, the question is the appropriateness of service that they are getting in the nonspecialty mental health care sector, that is, in primary care, or nursing homes. A lot of not really terrific practice goes on to treat things that are vaguely like mental health problems except they are not really identified as such and they are not really addressed in a systematic way either by the primary care physician or in a referral to a specialized mental health care professional.

Ms. BONJEAN. In terms of treatment issues, I was talking about treating in context. I think that sometimes we forget about the family that is attached to the older person and that they, in fact, may be one of our case finders because many older adults who may come for some psychotherapy may be coming because an adult child or another relative has recognized the symptoms and is asking them to come or is coming with them. Part of what we need are well-trained professionals who can address that whole context, not only the older adult alone leaving out the interested family member, but bringing the family member in and supporting them as a part of our intervention process so that then they can continue their support of the older person.

Ms. OSGOOD. I think with respect to elderly substance abusers, alcoholics and drug abusers, whether it is over-the-counter, prescription, or hard core drugs as well or dual addicted elders who are abusing drugs and alcohol at the same time, I think we do an even poorer job of recognizing, identifying, and getting help for that group than for many of the other groups. Substance abusers are a particularly vulnerable group that are not recognized and not treated.

Mr. RICKARDS. Thank you very much. I am afraid with our schedule we have to move along. Thank you very much for your comments and your answers.

Ms. COLEMAN. Let me say that what we hope that the important information that we are learning today will be captured in a committee print published by the Senate Aging Committee. We are also hopeful that if anyone has additional questions and/or state-

ments about the issues that are raised today that they will forward them to the Senate Aging Committee so that everything pertinent to today's discussion can be included in the record. The committee print will be an important educational document.

Our next panel represents a diversity from the helping professions. Dr. Peter Rabins has agreed to join us, leaving some reviews that he is doing at NIH today. So we thank you and I know that we're running late and I know that you're under a time pressure. Dr. Peter Rabins holds both an M.D. as well as has a master's in public health. He provides a bridge between many of the areas that we are attempting to consider today.

His area, as he puts it, of special interest is the psychiatric disorders in older persons, emotional, behavioral, and cognitive aspects of neurological illness. Remember, we talked about the efficacy of mental health treatment for older people and our goal with this second panel is to see how we meet the mental health needs of the elderly.

Our second speaker is Michael Smyer. Mick, as most people call him, is a professor of human development at Penn State. He has focused a lot on mental health treatment issues and has done research in this field. Most recently he was the editor of a special issue of Generations, the magazine of the American Society on Aging, where he gathered articles from researchers, policy analysts, and advocates, some of whom are here today, to look at mental health and aging issues. This issue of Generations will be used to educate policymakers, researchers, and service providers about mental health and aging.

Our third speaker is Marianne Smith. We asked Marianne to join us today to look at questions of access to mental health services for rural elders. Marianne Smith is a nurse and has been working in the delivery of mental health services in Iowa. She also works with a number of researchers in Iowa on the delivery of services. In addition, she provides mental health services and provides training to others who have contact with older people about identifying indicators of mental health problems.

Our last panel member is Dr. Harriet McComb. She has recently joined the Center for Mental Health Services as a public health advisor in the prevention branch. She is responsible for the agency's work with special populations. Prior to coming to NIMH, she was the research director for the Columbia area mental health center and an associate professor at the Department of Neuropsychiatry at the University of South Carolina. We have asked Dr. McComb today to talk to us about special access problems for ethnic minorities.

The organizers of today's forum asked Larry Rickards, as the first Chair of the Mental Health and Aging Coalition, to jointly Chair this event. The reason Dr. Rickards is not listed on your programs was that Larry called me on Monday, as I was about to get on a plane, and said, "Oh, Nancy, I have just had a call and I am going to go to Iowa"—or Illinois or Missouri or one of those States—"to help out in the flood disaster relief." We are lucky because the FEMA people just haven't quite gotten his travel records together so that is why he is here with us today. I didn't know

until we walked in this morning whether or not he was actually going to be able to be here.

Dr. Rabins.

STATEMENT OF PETER RABINS, M.D., JOHNS HOPKINS HOSPITAL

Dr. RABINS. Thank you, Nancy. It is a real pleasure to be invited to address the audience on biomedical and research aspects of efficacy and access. I would like to say at the start that although we've separated testimony into biomedical and psychosocial issues, in fact, it is truer in the aging than in any other age group that these two are intertwined to such a degree that it is really artificial to separate them. Nonetheless, I think for discussion purposes separation is useful.

What I thought I would do would is to briefly summarize my longer testimony that I put together. I would like to start with a little history as Dr. Lebowitz did and to go back to the 1950's when efficacy research was being developed. Most people don't appreciate the fact that the scientific techniques we use now to determine if a treatment is efficacious were developed, in large part, from the study of mental treatments. There was so much skepticism about whether medication or psychotherapy worked that technologies were developed to test those techniques and then were also applied to the study of indications for high blood pressure and anti-arrhythmic drugs. I mention this because Senator Talmadge's question, is treatment really efficacious, is still a question in many people's minds. And yet, for 40 years studies have been carried out and clearly demonstrate that both biological and psychosocial treatments are effective in people of all ages.

When we focus specifically on mental disorders in older people, there is a huge body of information to show that treatments for depression, manic depression, schizophrenia, obsessive compulsive disorder, and anxiety respond to the biomedical treatments for these disorders to much greater rates than for placebo treatments. Evidence is weaker that we can effectively treat the behavioral symptoms of Alzheimer's disease and other dementias but there is some evidence that we can do that as well.

Surprising to many people is the fact that electro-convulsive therapy is still done. In fact there is an extensive literature to demonstrate the electro-convulsive therapy or ECT is an effective biomedical treatment—in fact, it is the most effective treatment for depression, more effective than medications. Ironically, it is the safest treatment for depression. For many older people who are not able to tolerate medicines or who have medical conditions that complicate their care, electro-convulsive therapy is the only treatment that they can tolerate.

As far as access, studies dating back over the past decade demonstrate that the percentage of older people who have mental disorder is about the same as the percentage of middle aged and younger people. That is, over the life span the prevalence of mental problems is about the same. Yet, if you look at the percentage of people who receive mental health treatment, the elderly are less likely to be in treatment by far. And even within the elderly this is very much an age related phenomena. In the ECA study, a large

NIMH-funded study in which more than 20,000 Americans were interviewed almost no one over the age of 75 was receiving mental health treatment from anybody, doctor, social worker, nurse, or medical practitioner, even though the evidence shows, again, that the rates of disorder in the over 75 are as high as they are in other age groups.

Thus, it is very clear that we have a serious access problem. That is, for some reason, and I think that there are several reasons, older people are not gaining access to the good treatments that we do have. One has to wonder whether reimbursement, stigma, and just lack of knowledge all contribute.

The next point that I want to make is one that has already been made but I think it bears repeating. In older people the co-occurrence of physical and psychological problems is extremely high.

The slide showed that if you look at a variety of different medical illness that the rates of depression vary between 15 and 30 percent. If you take a condition like Parkinson's disease which is relatively common in older people, about 30 percent of patients have a severe depression that meets diagnostic criteria. And the other slide I was going to show demonstrated that the biomedical treatments we have to treat depression in the physically ill are as effective in people with these medical illnesses as they are in people without those illnesses and as effective as in the young. The fact that you have had a stroke, a heart attack, kidney trouble and also have depression in no way interferes with the fact that you will respond to treatment for the depression. Unfortunately, that is not well known. It is far too common for people to say, "well, who wouldn't be depressed not just because you are old but because you have X, Y, or Z" and then not refer a person or not initiate appropriate treatment. This is an example of lack of information being a cause of undertreatment.

The final broad point I want to make was one that Dr. Cohen also made. There is a very extensive body of literature to show that the treatment of emotional disorder in late life is cost-effective. That is, it not only improves people's mood, for example if it is depression, but makes people more functional, increases the number of social contacts that they have, and improves their activities of daily living function. For example, people who are depressed and get well are more able to physically care for themselves. Treatment shortens the length to stay in medical hospitals, as has been mentioned, and decreases disability. Therefore, it is very clear, to me at least, that when we talk separately about mental illness and physical illness that this is another false dichotomy. We are talking about people who have several diseases and for convenience we call some of them psychological and some of them medical. The bottom line, however, is that we are talking about illnesses that rob people of their function.

The final point that I wanted to mention was what I believe the research agenda should address. Even though we have effective treatments they are not as good as we need. We need safer and more effective treatments than we have now. For example, a single trial of an anti-depressant medicine is effective in about 60 percent of people and ECT in 90 percent. That means there are people who don't get better. Furthermore, many of the treatments we have

have serious side effects. We also need more research that looks at the interaction between biological and psychosocial factors. It is a mistake to treat them separately.

As has already has been mentioned, we need methods to improve the dissemination of the knowledge that we do have. It is clear to me that part of the reason that older people are undertreated for their mental health problems is that professionals, doctors, nurses, social workers, and the lay of public do not know that there are effective treatments available. We have to somehow do a better job at teaching people that treatment is available. I believe we need research to figure out how can we do a better job at that.

I believe we need research to focus on why the elderly are not accessing and using the services that are available. Some of these factors lie within older people themselves—there probably is more stigma about having mental disorder in older people—but as many other people have already mentioned, many of the factors lie in the health care system itself. We are not meeting the needs and designing services, as Dr. Cohen said, that bring treatment to people rather than force them to come to us.

Finally I also want to mention the fact that, as Dr. Lebowitz noted, that we are often talking about chronic conditions. That is conditions that get better with care and treatment but that may recur over time. We need research to tell us how can we do a better job at preventing recurrence, preventing relapse, and keeping people well once they do improve.

Thank you very much.

[The prepared statement of Dr. Rabins follows:]

BIOMEDICAL AND RESEARCH ASPECTS OF THE EFFICACY OF MENTAL HEALTH TREATMENT FOR THE ELDERLY

Testimony of Peter V. Rabins, M.D., M.P.H.

Department of Psychiatry, Johns Hopkins University School of Medicine
Baltimore, Maryland 21287

Thank you for inviting me to testify at this briefing. I have been asked to address the biomedical and research aspects of the efficacy of mental health treatment for the elderly. While I will limit my remarks to this topic I want to emphasize that biomedical and psychosocial treatments must be applied in tandem for each to achieve maximum benefit.

The word *efficacy* refers to scientific evidence that a specific treatment improves or cures a symptom, condition or disease. In times of shrinking resources, such as we are living through now, questions about efficacy are particularly important since we would like to use our limited resources to address problems that are not only important but for which effective treatments exist. The development of biomedical therapies and research into their efficacy has focused on the serious and persistent mental illnesses of late life. These are depression and manic depressive illness; the dementias of various etiologies; schizophrenia and chronic paranoid conditions; obsessive-compulsive disorder; chronic anxiety disorders and severe personality disorder. Evidence from the NIMH supported Epidemiologic Catchment Area study demonstrated that, together, the severe form of these conditions affect approximately 8% of persons over 65 during any 6 month period. It is important to recognize that the majority of persons who suffer from one of these disorders are cared for by family members who also experience emotional, physical and financial strains.

What is the evidence that available biological therapies are effective in the elderly? I will address them by specific disorder.

THE EFFICACY OF BIOLOGIC THERAPIES OF SPECIFIC DISORDERS

1. Depression and manic depressive illness. Many studies show that effective biological treatments are available for depression and manic depressive illness. The most commonly prescribed biological treatments are medications. A number of different compounds are available for prescription and each of these is effective in approximately 60% of individuals. This is double the rate of response to so-called placebo treatments. More severe depression often requires the addition of other medications. Clearly a significant majority of older individuals with depression respond to medication therapy.

The most effective treatment for depression, however, is electroconvulsive therapy or ECT. Unfortunately ECT has been identified as a frightening and undesirable treatment. This is likely due, in part, to the manner in which ECT was administered in the past. The use of anesthesia, muscle relaxants and careful medical monitoring have vastly improved its acceptability. Studies of efficacy demonstrate that ECT is effective in 90-95% of individuals with moderate or severe depression. Furthermore, and surprising to most observers, ECT is safer than medications. Because the depressed elderly often suffer from severe medical problems which make the prescription of medications dangerous or even contraindicated, ECT may be the only therapy available.

Although less well studied, the manic phase of manic depressive illness also responds to medication therapy. Compounds such as lithium carbonate and carbamazepine are as effective in the elderly as in the young. They decrease the frequency of recurrence of manic depressive illness as well as treating individual episodes.

2. Dementia is common in the elderly and is caused by many diseases. Alzheimer disease is the most common cause. In landmark studies supported by the National Institute on Aging, the medication tacrine has been shown to mildly improve memory and daily functioning. However, evidence to date does not suggest that this compound will reverse or slow down the progression of Alzheimer disease. Fifty to 70% of patients with Alzheimer's disease and other dementias also suffer from moderate or severe behavior or emotional symptoms. These are often more problematic to caregivers than memory impairment. The best evidence we have suggests that available antipsychotic or neuroleptic drugs are mildly effective in treating certain behavioral symptoms. The evidence that depression in Alzheimer's disease responds to medications is primarily anecdotal although one study demonstrated that antidepressant medication and psychosocial support were equally effective in improving mood in patients with Alzheimer's disease. In my opinion, more studies of currently available medications and the development of new compounds to treat the behavioral complications of dementia and Alzheimer's disease should be a high priority because a primary treatment or prevention for Alzheimer's disease may not be found for many years.

It is important to emphasize that there are treatments and preventions for other causes of dementia. The second most common cause of dementia, vascular dementia, is often caused by stroke or blood vessel disease. Studies have demonstrated that low dose aspirin or anticoagulant therapies can prevent the progression of vascular dementia by improving brain blood flow. Unfortunately, this information is not well known. In my opinion further research is needed to develop methods for identifying individuals who have this type of dementia. Concerted educational efforts aimed at physicians, other health practitioners and the lay public that will improve the identification individuals who have had small strokes and brain blood vessel disease is sorely needed.

3. Schizophrenia is a less common disorder in older people than in the young. Medications have been available for 40 years to treat the symptoms of schizophrenia and anecdotal research suggests that elderly individuals with schizophrenia respond to these medications at the same rate as younger individuals. However, the elderly are more prone to developing serious side effects than younger persons. I believe an important research agenda should be the identification of safer compounds that will relieve the chief symptoms of schizophrenia and prevent the deterioration that schizophrenia sometimes causes but have fewer side effects.

4. Obsessive-compulsive disorder is usually a life long disorder. Effective biological treatments have been available for only several years but these appear to be equally effective in younger and older individuals. The use of these medicines in older individuals is often limited by their side effect profile. Thus, the development of more effective, safer treatments should be supported.

5. The anxiety disorders are common in older individuals but, ironically, are less well studied. Medications are available to relieve the symptoms of chronic anxiety and to prevent panic attacks. More studies are needed, however, to identify medicines with safe side effect profiles.

PSYCHIATRIC SYMPTOMS AND PSYCHIATRIC DISORDERS OCCURRING SECONDARILY TO OR CONCOMITANTLY WITH PHYSICAL ILLNESS

Medical illness and psychiatric disorder occur together frequently in the elderly. Many psychiatrists, physicians, psychologists, social workers and other mental health practitioners are intimidated by this co-morbidity because they feel that they have not been adequately trained to treat individuals who have both medical and psychiatric symptoms. This is unfortunate since the psychiatric symptoms are often treatable even when the underlying disorder is not. I have already talked about the fact that certain behavioral and mood symptoms of Alzheimer's disease respond to biological therapies. In addition, the depression that commonly occurs in association with specific medical illnesses, for example stroke and Parkinson's disease, respond to the same biological treatments as does idiopathic (without an identifiable cause) depression. In addition to improving depression, these therapies also improve physical function, increase the participation in and success of rehabilitation and shorten the length of medical hospitalization.

While we know that both medications and electroconvulsive therapy are efficacious in treating depression in the medically ill, this fact is not widely appreciated by physicians, non-physician mental health practitioners or the lay public. We need to develop new methods of identifying depression in the medically ill elderly and of disseminating this technology and knowledge.

Targeted NIH support is needed to develop safer and or more effective agents. Increasing collaboration between private industry and researchers supported by the NIH should be encouraged and will help clear up this problem. Concerted efforts to disseminate available knowledge to professionals and the lay public are needed to change incorrect assumptions.

Additional research is needed to study biomedical treatments of alcohol and substance abuse in older individuals, to identify of novel ways of treating seriously mentally ill persons who live alone and who reside in nursing homes, live in special elderly housing sites or who are so physically impaired that they are unable to present for treatment to office-based practitioners.

The biological therapies that we have now to treat serious persistent mental disorder in older individuals are not perfect. However, we are not adequately utilizing the treatments that are available. Other important research questions include: a) the identification of more effective and safer biological therapies; b) the identification of individuals who will respond to available therapies; c) research is needed into the best methods of training mental health practitioners, non-psychiatric physicians and using individuals not traditionally thought of as providing mental health services (such as community workers who have contact with the elderly) Finally research should identify the best ways to increase knowledge among professionals and the pay public. Effective treatments are available and that the stigma associated with accepting mental health therapy would maximize the use of the effective treatments that are now available.

SUMMARY

1. Effective biological therapies are available to treat the serious and persistent psychiatric conditions that occur in the elderly: depression, manic depression, schizophrenia, behavioral complications of dementia, obsessive-compulsive disorder and chronic anxiety.

2. Electroconvulsive therapy is often safer than medication treatment and has a unique role to play in the seve. ely medically ill whose medical condition makes them unable to tolerate standard antidepressant treatments.

3. The major barriers to the use of effective biological treatments in the elderly are: a) lack of knowledge among practicing physicians and non-physician mental health practitioners; b) the incorrect presumption that psychological distress in the elderly is a normal aspect of aging; c) the presence of concomitant physical illness and the side effect profiles of the available treatments.

I would like to end where I began. Biological treatments are most effective when they are combined with appropriate assessment and psychosocial care. Research into the combined use of biological and non-biological therapies is very likely, in my opinion, to maximize the effectiveness of the agents we already have.

STATEMENT OF MICHAEL SMYER, PROFESSOR OF HUMAN DEVELOPMENT, THE PENNSYLVANIA STATE UNIVERSITY

Mr. SMYER. Madam Chairman, I will outline my remarks and if I am successful in speaking in under 7 minutes, I will yield the rest of my time. First, I appreciate your organizing the forum this morning.

I would like to cover four areas very briefly. I am going to spend a little more time on access and efficacy issues, giving a little bit of the statistics that Barry mentioned a little earlier. I am going to skip over a lot of what I had to say about efficacy in the areas of cognitive dysfunction and depression because Peter has covered some of those areas. I want to highlight anxiety disorders as a particular case in point where the interaction of physical and psychological functioning is crucial to look at in older adults. Then I want to turn to one setting where these issues are clearly salient, and that is nursing homes. I know you're thinking why worry about nursing homes. But I hope that by the end of the 7 minutes you will think more seriously about the role of nursing homes in your future, in your family's future, as well as in the mental health system. And finally, I will conclude with some comments on the importance of preventive efforts and priorities for action. You see, I am doing this without slides and that allows me to run through things pretty quickly.

To begin with access and efficacy, my colleague and friend Linda George at Duke recently summarized the literature on community and home care for mentally ill elderly. Her summary aptly captures the situation. She said, "It is ironic that at a time when there is more and better research about the causes and effective treatment for psychiatric disorders the mental health delivery system is underfunded and underutilized." She is right on target. There are three elements I think that underscore Linda George's summary. First, the general medical sector, that is primary care physicians, provide a large portion of the diagnostic and treatment services to older adults who have mental health problems. Second, those primary care physicians poorly recognize psychological symptoms in older patients and are less likely to refer those older patients with mental disorders for specialty treatment than they are to refer younger patients. Third, those general medical providers are much more likely to prescribe psychotropic medications for patients with mental health problems than are mental health specialists. In short, primary care physicians play a central role in treating mental disorders of the elderly even though they are not particularly well-skilled at detection and appropriate treatment of such disorders.

But it is not solely the role of the primary care physicians that we need to focus on in terms of access. Individual characteristics also lend themselves to different treatment patterns. For example, again Linda George provided a concise summary, "lower income and education, being a member of a racial or ethnic minority, being male, and being old are all associated with a lower likelihood of receiving mental health services even in the presence of the need for such services." There are organizational factors, however, that can affect the availability and use of services. Barry Lebowitz and others have noted that community mental health centers which have

targeted older adults for service use have higher rates of utilization and higher rates of treatment. Unfortunately, such coordination and targeting is the exception rather than the rule.

My colleague Margy Gatz and I have recently summarized the current delivery system. The mental health system has shifted over the last two decades. Private institutional settings have been created and the Government has become a major third-party payer through Medicare and Medicaid. Finally, there has been little or no coordination or cooperation among components of the mental health system in part because of multiple funding sources and in part because of organizational and guild issues that often obscure genuine concern for older adults. Nursing homes, which you will hear more about in a minute, have not been integrated into any mental health system although the Nursing Home Reform Act mandates active treatment. The upshot is that both everyone and no one is responsible for clients. A non-system of mental health care has emerged.

But don't get depressed or if you do see Peter because, as you know, we have effective treatments for depression. In my written comments I highlight the efficacy data on treatment of behavioral aspects of cognitive impairment, particularly of the dementias as behavioral and mood disorders, efficacy data on effective treatments of depression, including but not limited to ECT, other approaches such as cognitive behavior therapy have been found to be effective with older adults even using para-professional therapists, not solely Ph.D. or M.D. therapists.

But I want to focus my brief remarks on anxiety disorders, another mental health problem that requires attention. Prevalence rates suggest that about 5 percent of the elderly have an anxiety disorder with another 10 to 20 percent of older adults having anxiety symptoms. There are effective pharmacological and psychological approaches for anxiety disorders although the efficacy date here is not as solid as in the depressive disorders, in part because the drugs developed to treat anxiety disorders have primarily been tested with younger adult samples.

Pharmaco-therapy of geriatric anxiety relies primarily on benzodiazapine such as halcyon with a short elimination half-life or Librium or Valium with longer half-lives. These approaches have a down side to them in that there is an increased possibility for toxic reactions with benzodiazapine use in old age. Adverse reactions include day time sedation, unsteadiness leading to falls and fractures, and cognitive impairment and confusion induced by the treatment itself. Because of the potential toxicity of such drug regimens, psychological interventions are often viewed as a treatment of choice or certainly an important part of the therapy process. Unfortunately, many times these anti-anxiety agents are prescribed by primary care physicians who are not well attuned to the need for close follow-up with their older patients.

A setting in which these issues become increasingly important is nursing homes. You know as well as I do that at any one point in time 5 percent of the elderly are in nursing homes. This cross-sectional view, however, hides the lifetime prevalence rates of nursing home use. Recent estimates suggest that one-third of men and a little over half of women turning 65 in 1990 could expect to use a

nursing home sometime before death. Why is this important in a hearing on mental health and aging? Because roughly two-thirds of those in nursing homes have at least one diagnosable mental disorder. Put another way, nursing homes now provide roughly 26 percent of all in-patient mental health services. Nursing homes have become the major receiving site for mentally ill elderly in our society. They have come to play a mental health as well as a physical role. Are they staffed for this? No. Do they provide mental health services? The Readers Digest version is, no.

Barbara Burns and her colleagues recently reported that during a 1-month period of time roughly 5 percent of the mentally ill in nursing homes receive any mental health services and half of that is provided by primary care physicians. Our own group at Penn State has done a study suggesting that over a 1-year period of time roughly 19 percent of diagnosed mentally ill elders receive any type of mental health treatment. Clearly, there is a need for greater treatment there and we can talk in the discussion about why we don't provide the treatments that we know can be effective in this setting and the key role of nursing assistants in that setting.

In closing, I want to highlight four things: First, we need to find ways to improve the ability of primary care physicians to more accurately diagnose and treat mental disorders among the elderly and to more effectively refer to specialty treatment as appropriate. Second, within the institutional setting, primarily nursing homes, we need to develop more effective treatment strategies for nursing home residents with mental disorders and with the combination of physical and mental disorders because the co-morbidity issues we've heard so much about this morning are particularly salient there. Effective treatment strategies must include involving nursing assistants, the primary care providers in nursing homes, as mental health providers as well as physical care providers. In the community, third, we need to encourage more effective collaboration between and among the diverse settings that serve mentally ill older adults; for example, AAAs, Area Agencies on Aging, and community mental health centers. And finally, because of the potential for adverse drug reactions and drug toxicity and inappropriate self-medication among older adults, often psychological therapies and psycho-social treatment choices are treatments of choice for older adults who have both co-morbidity of physical and mental health problems.

In closing, however, I want to emphasize one other theme, and we've heard it before but I think it is important to underscore, and that is that the majority of older adults do not have mental disorders. Although it is important to focus attention and resources on mentally ill elderly, we have much to learn from their mentally resilient age peers about successful adaptation to the substantial challenges of later life. Optimally, research and intervention approaches must reflect both the diverse clinical settings serving mentally ill elderly—for example, primary care physicians, general hospitals, nursing homes—as well as the diverse older population itself.

I yield the rest of my time.

[The prepared statement of Mr. Smyer follows:]

REMARKS OF

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FOR A BRIEFING SPONSORED BY

THE

UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

AND THE

COALITION ON MENTAL HEALTH AND AGING

ON THE SUBJECT OF

MENTAL HEALTH AND THE ELDERLY

JULY 15, 1993

Introduction

Mr. Chairman, thank you for giving me the opportunity to appear today. My name is Michael Smyer. I am a clinical psychologist by training and a licensed psychologist in the Commonwealth of Pennsylvania. I am currently a Professor of Human Development at Pennsylvania State University.

I am a fellow of the American Psychological Association, the American Psychological Society, and the Gerontological Society of America. I am currently the President of the Division of Adult Development and Aging of the American Psychological Association.

For more than fifteen years, I have been involved in research, education, and program development in the area of aging and mental health. During this time, I have been a founding board member of a 92-bed free-standing inpatient mental health facility, the Meadows Psychiatric Clinic in Centre Hall, Pennsylvania, and a founding board member of a continuing care retirement community that serves 200 older adults, Foxdale Village in State College, Pennsylvania. In addition, I have pursued a program of research focusing on effective mental health treatment approaches for older adults, especially nursing home residents (see Smyer, Cohn, & Brannon, 1988, & Smyer, Brannon, & Cohn, 1992).

In my comments this morning, I will be drawing from several recent reviews of mental health treatment approaches for older adults (e.g., Cavanaugh, Park, Smith, & Smyer, 1993; Finkel, 1993; Gatz & Smyer, 1992; George, 1992; Smyer, Zarit, & Qualls, 1990). In doing so, I will highlight what we know and what we need to know in several key areas. I will begin with a brief review of issues of access and efficacy of mental health treatment. Next, I will summarize briefly the state of knowledge in three important

substantive areas: cognitive impairments in later life, primarily dementia; depression; and anxiety disorders. Third, I will focus on the important treatment issues that arise in nursing homes. Finally, I will conclude with brief comments regarding the importance of preventive efforts and priorities for action.

Access and Efficacy:

Linda George's (1992) recent review of community and home care for mentally ill older adults aptly summarizes the current situation:

> It is ironic that, at a time when there is more and better research about the causes and effective treatment for psychiatric disorders, the mental health delivery system is underfunded and underutilized. (1992, p. 793)

WHAT WE KNOW

George's summary reflects several important patterns of mental health service use: 1) The general medical sector, rather than mental health specialists, provides the majority of diagnostic and treatment services to older adults who seek outpatient mental health care (George et al., 1988; Leaf et al., 1988); 2) General physicians poorly recognize psychological symptoms in older patients and are less likely to refer older adults for treatment, compared with younger adults, even with equivalent mental symptoms (e.g., Kucharski et al., 1979; Rapp et al., 1988); 3) General medical providers are much more likely to prescribe psychotropic medications for patients with mental health problems than are mental health professionals (e.g., Schurman et al., 1985). In short, primary care physicians play a central role in treating mental disorders of older adults, even though they are not skilled at detection and appropriate treatment of older adults' mental disorders (Waxman & Carner, 1984).

These service provision patterns provide a context for information on the prevalence of treatment for older adults' mental disorders. George (1992) recently reviewed several studies of "treated prevalence"-- the proportion of the population with a disease or disorder who are receiving care for the disease. She noted that approximately 60% of older adults' mental illness is due to nonorganic psychiatric or psychological disorders and roughly 40% is due to organic mental disorders (George et al., 1988).

Overall, treated prevalence rates for older adults range from 42% to 63%, depending upon the samples used and the definitions of mental disorders (Burns & Taube, 1990; George et al., 1988). George (1992) noted that older adults were no more likely than younger adults to lack treatment.

This general pattern, however, does not reflect different treatment experiences for older adults with severe cognitive impairment, primarily organic mental disorders, such as dementia. Older adults with this type of mental impairment were less likely to have received outpatient treatment than older adults without cognitive impairment. They were more likely, however, to receive inpatient care (George et al., 1991).

These general trends, however, are affected by the individual older adult's characteristics. Again, George (1992) provides a concise summary:

> ...Lower income and education, being a member of a racial or ethnic minority, being male, and being old are all associated with lower likelihood of receiving mental health services in the presence of the need for such services (Kessler et al., 1981; Kulka et al., 1979; Leaf et al., 1985).

Another element that affects older adults' access to mental health services is the coordination of services between the mental health system and the "aging network" (e.g., Area Agencies on Aging). Regional and national surveys have shown that community mental health centers' (CMHCs) targeting of older adults is associated with higher utilization rates (Knight, 1986; Lebowitz et al., 1987; Spore & Atchley, 1990). Specialization often entails providing services at sites other than the CMHC and establishing affiliations with the Area Agency on Aging.

Unfortunately, such coordination is more the exception than the rule. Gatz and Smyer's (1992) recent summary characterizes the current service delivery system:

> ...the mental health system has shifted, private institutional settings have been created, and the government has become a major third party payor through the vehicle of Medicare and Medicaid...Finally, there has been little or no coordination or cooperation among components of the mental health system, in part because of multiple funding sources and in part because organizational and guild issues often obscure genuine concern for older adults. Nursing homes have not been integrated into any mental health system,, although the Nursing Home Reform Act (OBRA, 1987) mandates "active treatment". The upshot is that both everyone and no one is responsible for the clients,..."a nonsystem of of mental health care" (Swan & McCall, 1987, p. 111)...p. 744

WHAT WE NEED TO KNOW

We need to understand two major aspects of mental health treatment patterns for older adults: the process of help seeking and service use by mentally ill older adults; and the differential effectiveness of various treatment approaches for older adults. We have little information about the different pathways to treatment for mentally ill elderly, and the outcomes associated with each.

We also need more information about how older adults with organic disorders (e.g., Light & Lebowitz,1990; Miller & Cohen,1987) and the chronically mentally ill elderly (Light & Lebowitz, 1991) access services.

In addition, we need information about the most effective ways to improve mental health service provision by primary care physicians, the gatekeepers for outpatient services. Assessments of the effectiveness of medical school training, in-service continuing education efforts, and other approaches are needed. Efforts to improve the knowledge and skills of these gatekeepers--either during their medical training or through continuing education efforts--could have a substantial impact on older adults' access to effective treatment approaches.

This general depiction provides a context for considering three of the most prevalent mental disorders of older adults: cognitive impairment (primarily dementia), depression, and anxiety disorders.

COGNITIVE IMPAIRMENT

Alzheimer's disease and other forms of dementia continue to be primary mental disorders of aging. Alzheimer's disease and related dementing disorders are brain diseases that alter not only cognitive functioning, but also behavioral, emotional, and social functioning. About three to four million Americans are affected by permanent, debilitating, and often progressive cognitive and behavioral losses, with 20-25% of the 85+ age group experiencing this problem (Advisory Panel in Alzheimer's Disease, 1993). Because of the aging of our society, it is expected that the prevalence of this problem with triple within 50 years (Schneider & Guralnick, 1990). Dementia has both emotional and economic costs. The long-term care required by dementia patients is highly stressful for their primary caregivers: family members (Light & Lebowitz, 1992). Economically, the direct and indirect costs for caring for dementia patients have been estimated to exceed $80 billion per year (Advisory Panel on Alzheimer's Disease, 1993).

WHAT WE KNOW

The progression of cognitive dysfunction associated with Alzheimer's disease has been well documented, and the behavioral and emotional effects of Alzheimer's are beginning to be better described (Raskind & Peskind, 1992). Through testing techniques developed by neuropsychologists and psychophysiologists (e.g., Kaszniak, 1990; La Rue, et al., 1992), as well as through neuroradiological techniques (e.g., Tune, 1993), we can effectively diagnose different types of dementia, with an improved understanding of the basic mechanisms of cognitive and behavioral decline in these disorders.

Although we cannot eliminate the cognitive decline caused by underlying dementias, we can and do have treatments--both pharmacological and psychosocial-- that are effective in treating the mood and behavioral aspects of dementing illnesses (e.g., Baltes & Werner-Wahl, 1987; Burgio & Engel, 1987; Hussian, 1987). (See Raskind & Peskind, 1992, and Regnier & Pynos, 1992 for reviews of these areas.)

WHAT WE NEED TO KNOW

It is urgent that better strategies be developed to differentiate various forms of dementia, early stages of dementia, and to differentiate dementia from depression. The goal is to develop an effective and efficient set of assessment strategies and improve diagnostic accuracy. To accomplish this, studies need to be conducted that document relationships among non-invasive psychophysiological, neuropsychological, and behavioral indicators to determine how these relate to one another. Similarly, research on the behavioral psychopharmacology of medications commonly prescribed for older adults can help develop safe and effective medication treatment, while avoiding the unwanted side effects (e.g., confusion and disorientation)that are common among older adults.

Interventions for dementia are needed on a number of fronts, including therapeutic interventions to assist the recently-diagnosed individual in early stages, who may be in great distress. Appropriate support and interventions for both the individual and the family also must be developed for later stages of the disease. In particular, the behavioral aspects of dementia have been relatively understudied, both in terms of basic descriptive research and intervention. Also, little is known about appropriate support interventions for members of different ethnic groups. Members of minority ethnic groups use established mental health services less frequently than do members of other groups. Different traditions and different understandings regarding dementia may require different intervention techniques to be effective (Wykle & Musil, 1993).

DEPRESSION

Depression is a clinical syndrome, including a constellation of physiological, affective, and cognitive manifestations, that affects older adults in a variety of ways. Nearly 5 million individuals age 65 and over suffer from serious and persistent symptoms of depression (e.g., disturbed sleep; changes in appetite

and weight; depressed or irritable mood; etc.), and over 1 million suffer from major depression (NIH Consensus Panel, 1992). In institutions (e.g., nursing homes), 25% of residents have major depression. Most of the treatment for older adults' depression occurs in the context of a primary care medical practice, with only a small minority of depressed older adults being treated by a mental health practitioner. Thus, depression among older adults often goes undetected and untreated, seriously eroding the quality of life and productivity of older adults.

WHAT WE KNOW

Well accepted, standardized methods for evaluating depressive symptoms and disorders in older adults have been developed (Blazer, 1982; Koenig & Blazer, 1992). In addition, effective treatment approaches for depression have been developed, including both pharmaceutical (Alexopoulos, 1992; Salzman, 1990; Salzman & Nevis-Olesen, 1992) and psychotherapeutic approaches (Gallagher & Thompson, 1982; Jarvik et al., 1982; Steuer et al., 1984; Thompson et al., 1987).

WHAT WE NEED TO KNOW

The relationship between susceptibility to depression and normal, age-related changes in brain structure and chemistry is poorly understood. Moreover, the possibility exists that depression in older adults is a clinically distinct syndrome, with somewhat differing causes, course, and symptoms than for younger adults (Alexopoulos et al., 1988). This is an area that needs urgent investigation, since it may lead to more effective treatment approaches. The goal is an improvement in the diagnosis and identification of older adults who are most likely to benefit from treatment.

Research is need to identify the optimal biological and psychological components of therapy for diverse groups of depressed older adults (e.g., those with late-onset depression v. life-long depressive disorder). In addition, adaptations of therapeutic approaches for older adults with various combinations of cognitive, communication, and depressive disorders should be explored. Similarly, clinical trials and observational studies are needed to identify optimal components of therapy for the very old, older adults from minority or underserved communities, institutionalized elderly, and older adults with a combination of physical illness and depression.

ANXIETY DISORDERS

Anxiety disorders constrain or severely impair the social functioning of affected older adults. The complexity of these disorders is captured by Gurian and Goisman's (1993) recent definition:

> Anxiety may be defined as a subjective state of internal discomfort, dread, and foreboding, accompanied by autonomic nervous system arousal (Gurian & Miner, 1991). Different from fear, anxiety tends to occur without apparent conscious stimulus. The term "anxiety" may refer to a mood state, affect, symptom, disorder, or class of disorders. The physical symptoms include hyperventilation, palpitations, sweating, diarrhea, trembling, dizziness, headache, restlessness, restlessness and muscle aches...Certain cognitive changes are also associated with anxiety states, for example, impaired attention, poor concentration, memory problems, and cognitions with anxiety-laden content....(p. 39)

WHAT WE KNOW

Estimates suggest that 5% of older adults have an anxiety disorder (Rabins, 1992). Prevalence rates for anxiety symptoms are even higher, ranging from 10 to 20% of older adults (Sheikh, 1992).

Effective psychological interventions for anxiety disorders among young adults have been developed, but their efficacy with older adults has not been fully established. For example, recent reviews have pointed out the applicability of behavioral approaches(e.g., Steuer et al., 1984), relaxation approaches (e.g., Yesavage et al., 1988), and other psychotherapies (e.g., Johsnon, 1991), while acknowledging the limited research base on efficacy with older adults (McCarthy et al., 1991).

Pharmacotherapy of geriatric anxiety relies almost exclusively on benzodiazepines, such as Halcion (with a short elimination half-life) or Librium or Valium (with a long elimination half-life). Unfortunately, there have been few treatment efficacy studies of benzodiazepines that include older adults (Salzman, 1991). In contrast, a sizeable body of research exists that consistently documents the increased probability for toxic reactions with benzodiazepine use in old age (Salzman, 1991, 1992). These adverse reactions include daytime sedation, unsteadiness leading to falls and fractures, and cognitive impairment (Salzman, 1992). Because of the potential toxicity of drug regimens, psychological interventions are often viewed as a treatment of choice.

WHAT WE NEED TO KNOW

It is difficult to differentiate anxiety disorders from depression among older adults; sensitive assessment techniques need to be developed to accomplish this (Sheikh, 1991). Similarly, assessment techniques should be developed to diagnose masked

presentations of anxiety disorders presented as physical symptoms and cognitive decline, since these may be viewed as more socially acceptable mechanisms for expressing emotional distress. Little is known about the optimally effective combination of pharmacological therapies and psychotherapies for treating anxiety disorders in older adults. Adaptations of successful therapies for younger adults need to be evaluated for the range of anxiety problems experienced by older adults. We also need to document more fully the impact of psychotherapy and pharmacotherapy on psychophysiological indicators of brain and heart function, as well as the biochemical mechanisms that accompany the experience of heightened anxiety among normal older adults.

NURSING HOMES

At any one point in time, 5% of older adults are using institutional settings, primarily nursing homes, as their formal source of support (Kastenbaum & Candy, 1973). In 1987, for example, there were slightly more than 1.5 million older adults in nursing homes (Lair & Lefkowitz, 1990).

The cross-sectional view belies the lifetime risks of nursing home use, however. Kemper and Murtaugh (1991), for example, used data from the National Long Term Care Survey to simulate the risks of nursing home care for members of a cohort turning 65 in 1990. They estimated that almost a third of men and just over half of women who turned 65 in 1990 could be expected to spend some time in a nursing home before death--substantially higher lifetime rates than the 5% cross-sectional view.

WHAT WE KNOW

Nursing home residents have a combination of physical and mental health problems. For example, Strahan and Burns (1991) summarized information from the 1985 National Nursing Home Survey. They found that 65% of nursing home residents have at least one mental disorder, including the dementias and other mental illnesses. Lair and Lefkowitz (1990), drawing on the 1987 National Medical Expenditure Survey (NMES), estimated that a similar proportion had a mental disorder. In addition, they found that a majority of nursing home residents need help with self-care activities (such as bathing, dressing, etc.)-- a common proxy for physical disability. In short, nursing home residents are both mentally and physically ill, with nursing homes now playing a major role in mental health care for older adults. Put another way, nursing homes now account for 26% of all inpatient mental health episodes (Gatz & Smyer, 1992).

Given the residents' mixture of mental and physical health problems, you might expect to find high rates of mental health service providers. Not so! Burns and her colleagues (1993), drawing on data from the National Nursing Home Survey, reported that only 4.5% of those with mental disorders received any mental health treatment in a month; half of that treatment was provided by primary care physicians. Similarly, Smyer and his colleagues (in press), drawing on the National Medical Expenditure Survey (NMES), reported that 80% of residents with a mental disorder were in a facility that reported providing mental health services. However, only 19% of those residents received mental health services during the previous year. There are a variety of effective treatment approaches that can be used in nursing homes: behavior therapy; cognitive-behavioral treatment for depression; group psychotherapy (see Smyer et al., 1988). However, they are unlikely to be applied (Liptzin, 1992; Smyer et al., 1988).

Nursing home administrators have a fiscal disincentive for accurately diagnosing and treating mental illness among their residents: the Medicaid reimbursement rate for a facility for the mentally ill and mentally retarded is substantially lower than that for nursing homes. Therefore, administrators may subtly (and perhaps even directly at times) influence the percentage of their residents who are given primary diagnoses of mental illness.

Not surprisingly, nursing home residents are intensive users of prescription medicines. A recent report summarized the situation:

> Sixty-one percent of the institutionalized elderly receive three or more different prescription drugs in a year; 37 percent receive five or more; and 19 percent seven or more. (HHS Inspector General, 1989).

Of more concern is the intense use of psychotropic medications within the nursing home setting (Buck, 1988). For example, Burns and Kamerow (1988) reported that 33% of the residents in a national sample were receiving a psychotropic medication. Of these, 21% had no diagnosis of mental disorder. Similar patterns of inappropriate use of psychotropic medications have been reported by other research groups (e.g., Beers et al., 1988; Monane et al., 1993; Spore et al., 1992).

Recent regulatory changes (e.g., OBRA 87) have emphasized the reduction of inappropriate chemical and physical restraints in nursing homes. In addition, application of psychological treatment approaches (particularly behavioral management and behavioral training approaches) have been encouraged. However, it is too early to assess the long-term impact of these regulatory efforts.

WHAT WE NEED TO KNOW

We need to understand more fully the patient histories that produce the currently high rates of mental disorders among nursing home residents. What role do public policy initiatives and regulatory barriers and incentives play in producing the current mixture of physical and mental health problems among nursing home residents?

Effective mental health treatment strategies should be developed, implemented, and evaluated to successfully treat the common symptoms of nursing home residents: depression, agitation, and disorientation. Equally important, effective strategies for using nursing assistants, the primary caregivers in the setting, as mental health technicians should be developed (see Smyer et al., 1992).

Comparative investigations of behavioral and pharmacologic approaches to disorientation, agitation, and depression among the residents should be pursued.

Finally, the effect of organizational elements (e.g., administrative climate, supervisory style, stable vs. rotating assignment of residents to aides) on mental health outcomes should be evaluated.

SUMMARY & CONCLUSIONS: THE OVERLOOKED ROLE OF PREVENTION

In these comments, I have summarized current information on patterns of service use and efficacy of treatment approaches for older adults' mental disorders. For three specific disorders-- cognitive impairment, depression, and anxiety disorders-- I have highlighted the strengths and weaknesses of our current research and clinical knowledge base. I have also emphasized the special challenges posed by mental health treatment within nursing homes.

In these areas, I want to highlight four themes:

> We need to find ways to improve the ability of primary care physicians to more accurately diagnose and treat mental disorders among the elderly;

> In the institution, we need to develop more effective treatment strategies for nursing home residents, with a special emphasis on using nursing assistants as a key treatment element;

> In the community, we need to encourage more effective collaboration between and among the diverse settings that serve mentally ill older adults (e.g., CMHCs and AAAs);

> Because of the potential for adverse drug reactions, and drug toxicity, psychological therapies are often the treatment of choice for older adults who have both mental and physical health problems.

In closing, however, I want to emphasize one more theme: **The majority of older adults do not have mental disorders.** Although it is important to focus attention and resources on mentally ill older adults, we have much to learn from their mentally resilient age-peers.

Individual adaptation in later life requires individual initiative in the self-maintenance of mental, physical, and social functioning (Cohen, 1993; Kivnick, 1993; Sherman, 1993). In addition to individual efforts, social resources (e.g., family members and friends) can act as buffers and moderators of the stresses of later life (Zarit, et al., 1993). Equally important, there are ethnic and gender differences in coping approaches and coping effectiveness (Wykle & Musil, 1993). In short, there is no single way to effectively respond to the normal stresses of later life.

Although the descriptive literature on effective responses to later life stress has increased during the last decade, there has been relatively little investigation of the effects of organized interventions to support such effective responses. For example, we need to understand the elements of effective coping that can be applied to programmatic interventions for a number of normal, developmental issues of later life: working through life-transition stresses (e.g., retirement, widowhood, etc.); coping with developmental crises; memory training; attacking the loneliness of later life; decision-making skills; developing new skills.

In addition, we need to understand the influence of adaptation across the life course: what is the impact of a person's mid-life response to stress on her adaptation in later life? What are the unique challenges to mental health among the oldest old (85+), the fastest growing portion of the older age groups? How does the interaction of the physical, mental, social, and economic determinants of positive mental health change in later adulthood, particularly among the oldest old?

Research is needed that will lead to the prevention and reduction of mental disorders among older persons. Specifically, research is needed to :

> examine individual differences among older adults in responding to the stresses and challenges of later life: Why do many older people who experience

risk factors for mental illness not develop subsequent problems, and what are the implications for preventive interventions?

> identify the unique challenges to mental health among the oldest-old (80+), the fastest growing portion of the elderly, and develop and evaluate preventive interventions targeted on their concerns;

> examine the inter-relationships between mental disorders and chronic physical illness, to develop effective preventive interventions for older adults who face the challenges of both physical and mental illness in later life.

Optimally, research and intervention approaches must reflect the diverse clinical settings serving mentally ill elderly (e.g., primary care physicians; general hospitals; nursing homes), as well as the diverse older population.

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STATEMENT OF HARRIET McCOMBS, PH.D., CENTER FOR MENTAL HEALTH SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Dr. McCOMBS. Good morning. First, I would like to thank the Committee for the invitation to participate in this briefing. After listening to several presenters, I have structured my comments perhaps in the form of a question; that if services are available, if they are effective, are they appropriate for specific ethnic minority groups? Furthermore, are they accessible to those groups? And if not, what do we need to do about it?

I think the services are available. I think they are effective. My questions are related to the appropriateness of the services and the accessibility of the services. I think there are a number of primary barriers to services for ethnic minorities, and that has to do with the lack of knowledge about mental illness in general, the lack of information about mental illness within specific ethnic groups, cultural stigma regarding mental illness, perceptions of discriminatory treatment, actual discriminatory treatment, lack of providers who have both knowledge of mental illness and ethnic culture, poverty, and the lack of family supports.

It is interesting to note that by the year 2030 persons who are considered ethnic minorities will constitute the majority of citizens in the United States and those over the age of 65 will constitute fully one-quarter of the total U.S. population. Major ethnic groups comprise several distinct subgroups. Black Americans include African-Americans and an increasing number of African-Caribbeans. Asian-Americans and Pacific Islanders include at least seven specific groups which includes Southeast Asian refugees. The Hispanic population includes five large subgroups based on national origin. And there are more than 400 American Indian and Alaska Native tribes and languages which are recognized.

So as a group, the elderly are underserved in psychiatric treatment. Specific data on blacks, Hispanics, American Indians, Alaska Natives, and Asian Pacific Islanders are lacking but we're reasonably able to conclude that ethnic minority elders are underserved in the mental health system. Unless the needs of this growing group are addressed in a culturally competent manner, that is to say in a way that knowledge is applied in a respectful and culturally competent way recognizing cultural differences, millions of elders will go underserved, millions will suffer treatable diseases and illnesses, families will undergo undue stress in their attempt to meet the needs of the mentally ill family member without adequate supports. Existing general and psychiatric services will be inappropriately used and the cost for treatment will be more expensive.

One of the things we need to recognize as we attempt to meet the needs of ethnic minority elders is that we need to recognize the particular differences between minority groups and the way they utilize mental health services. For example, as we've heard, suicide is more frequently found in elderly white men. The rate for suicide among African-Americans is much lower than it is for whites but higher for Asians.

Native Americans have been consistently identified as having high rates of depression; however, recent data on the rates of de-

pression and emotional distress for African-Americans are comparable to those of whites. Elderly blacks are more often diagnosed with schizophrenia, less likely to be diagnosed with anxiety disorders, and more likely to be hospitalized and in general receive less desirable mental health services.

With regard to treatment within psychiatric hospitals, more blacks, American Indians, and Alaska Natives are hospitalized in psychiatric facilities relative to whites. The hospitalization rates for Hispanics is somewhat lower than whites, and the rates for Asian Pacific Islanders is significantly lower. So we need to understand the differences within ethnic groups.

We also need to understand that there are cultural differences in the values of elderly persons and extended family networks and this may influence the use of mental health services. It has been reported in one study that among African-Americans there is a relatively short period of time between the onset of symptoms and the decision to seek treatment. A study of Japanese-Americans found that they are kept in their families for a longer period of time before being referred to services, And so we need to understand those differences.

Also, we need to understand the impact of discrimination on services. There exists a perception of inequality in treatment provided by the mental health system. A recent study reported that 1 out of 5 black family members of mentally ill clients felt that their family member would have been treated differently, presumably better, if they were white instead of black. These perceptions may have basis in fact. A recent study reported that despite equal access to supportive community services, controlling for social demographics, previous hospitalizations, diagnoses, time in program, blacks are found to be hospitalized more frequently than whites.

Income clearly affects the ability of ethnic elders to obtain the necessary medical care and mental health care. One out of every three blacks over the age of 65 is poor. Elder Hispanics have higher illiteracy rates and poverty rates which jeopardize their mental health. Elderly whites supplemented mental health care with Medicaid and additional insurance from private care at twice the rates of black elderly. So finances clearly impact access to services.

Furthermore, ethnic families are more likely to care for a mentally ill elder at home. And because of this practice, the caregiver is placed at risk for developing mental illness, particularly depression as the burden of the caregiving task increases.

Finally, I would like to raise the question again that if the services are available, if they are effective, are we providing appropriate services and are we providing accessible services. The elderly minority is likely to recognize symptoms but may not attribute them to mental illness. They lack information about mental illness and often avoid treatment because of stigma and family pressures related to the denial of illness and the perception of discrimination.

Unless we provide accurate information about mental illness, available outpatient treatment, information about costs to elders and their families, actively engage in reducing stigma within a cultural context, provide outreach services, and increase the number of persons trained to accurately diagnose the population, and eliminate the perception and the reality of discriminatory practice, mil-

lions of elders will go underserved, millions will suffer treatable illnesses, families will undergo undue stress in their attempt to meet the needs of the mentally ill family member, and general and psychiatric services will be inappropriately used, and costs for services will be more expensive.

Thank you.

[The prepared statement of Dr. McCombs follows:]

Access of Minority Elderly to Mental Health Services

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Abstract

This paper outlines the cultural imperative to develop models of culturally competent services for elderly minority persons, barriers to culturally competent services and the role of Federal, State and local agencies in eliminating barriers to mental health services.

Access of Minority Elderly to Mental Health Services

We have within our Nation a cultural imperative to enhance the access of minority elderly to appropriate mental health services. The imperative is grounded in facts presented in a recent article by F.M. Baker (1992).

> By the year 2030, persons who are considered members of ethnic minority groups will constitute the majority of the U.S. population and those over the age of 65 years will constitute 24% of the total U.S. population. Major ethnic groups comprise several distinct subgroups. Black Americans include African Americans and an increasing number of African Caribeans. Asian Americans and Pacific Islanders include at least seven specific groups, among them Southeast Asian refugees. The Hispanic American population includes five large subgroups based on national origin. More than 400 American Indian and Alaskan Native tribes and languages are recognized " (p. 337).

In 1988 the proportion of the population over 65 constituted 12.4 percent. Currently, it is estimated that 14-20% of older adults suffer from emotional problems serious enough to warrant mental health intervention. Sixteen to twenty-five percent of reported suicides are by those 65 and over. It is estimated that approximately 7.8% of all older persons residing the community have a need for psychiatric services, however, only 2.5 percent of community residing elders receive treatment from mental health professionals, and another 2.4 percent obtain care form their primary physician (Burns and Taub, 1990). In 1986 the elderly accounted for 8.7% of all inpatient psychiatric admissions and for 3.1% of outpatient admissions. As a group the elderly are under served in psychiatric treatment.

While specific data on the mental health status of Blacks, Hispanics, American Indians/Alaska Natives and Asian/Pacific Islanders elderly are absent, it can be reasonably concluded that minority elderly are under served in mental health services.

A survey of the primary barriers to services suggests that minorities are under served because of: a lack of general knowledge about mental illness among minority elders; a lack of data on mental illness within specific ethnic groups among providers; cultural stigma regarding mental illness; perceptions of discriminatory treatment; perceptions of cost for treatment; lack of providers who are both knowledgeable of mental illness and ethnic cultures, poverty; and a lack of social supports for family members caring for elderly persons with a mental illness.

Unless the needs of this growing group are addressed in a culturally competent manner, that is, one that is knowledgeable and respectful of cultural differences, millions of elders will go under served. Millions will suffer with treatable illnesses, families will undergo undue stress in their attempt to meet the needs of a mentally ill family member without adequate supports, existing general and psychiatric services will be used inappropriately, and cost for treatment will be more expensive.

Little is known about the characteristics, service needs, and the way elderly minority utilize mental health services. Any effort to improve services to minority elderly is tied, however, to our ability to understand both the unique service needs of the minority elderly, their providers, families and communities, and conditions which create barriers to culturally competent services. More evaluation research on minority elders' access to and use of mental health services.

The Substance Abuse and Mental Health Services Administration (SAMHSA) was established by Congress on October 1, 1992, to strengthen the Nation's delivery system for prevention and treatment services for persons with mental and addictive disorders. Within SAMHSA, The Center for Mental Health Services (CMHS) provides national leadership in planning, organizing and coordinating program to improve access to services for a variety of special populations including ethnic elders. Absent, however, is funding to support programs for elderly minorities.

Differential Service Needs and Tendencies in Seeking Care

The delivery of mental health services to minority elders requires providing them with services within the appropriate cultural context. Service providers, program directors and policy makers can not afford the risk of assuming statistical profiles of the "average" older mentally ill person accurately portray older minority individuals. Moreover, the tremendous heterogeneity between and with in groups, the manner in which particular racial and ethnic minority groups use mental health services cannot be overlooked.

There are differences among ethnic groups in their need for services, their view mental illness and persons exhibiting abnormal behaviors, their faith in the benefit of hospitalization, the capacity to maintain a mentally ill family member in the community, and access to, and use of alternative services. Examples of some differences follow.

Suicide is a more frequent cause of death among the elderly than among any other age group, although this is due primarily to the relatively high suicide rate among older White men. The rates among African-Americans are lower than the rates for Whites, but higher among Asian-Americans than it is for Whites.

Dysphoria and major depressive disorder are prevalent mental disorders among the aged (Bliwsie & McCall, 1985; Gurland & Toner, 1982). Native Americans have been consistently identified as having high rates of depression. Recent data on the rates of depression and emotional distress found the rates for African-Americans comparable to those of Whites (Revicki & Mitchel, 1990; Standford & DuBois, 1992).

Elderly Blacks are more likely than Whites to be over diagnosed with schizophrenia, underdiagnosed with anxiety disorders, more likely to be hospitalized and in general receive less desirable mental health services.

Cultural differences in values regarding the care of the elderly may influence the time it takes for families to seek help and their role as direct care giver of a mentally ill family member. It has been reported in one study, that among African-Americans there is a relatively short interval between the onset of symptoms and the decision to seek treatment (Dunham, 1965)

Two studies, one of Chinese Canadians and the other of Japanese Americans found that in comparison to Anglo Saxons and middle-Europeans, they are kept for longer periods of time within their families before being referred by their families or themselves to multiple service and mental health agencies (Lin, Tardiff, Donetz, and Goresky, 1978; Kitano, 1982).

More Blacks and American Indians/Alaska Natives are hospitalized in psychiatric facilities relative to Whites. The hospitalization rates for Hispanics are somewhat lower than Whites and the rates for Asian American/Pacific Islanders are significantly lower than those for Whites.

Minority elderly receive treatment less frequently than Whites in private agencies and hospitals. Unfortunately, little has been done to in the area of assuring that the private and the public sector demonstrate cultural competence in treatment of minority elderly.

The Major Barriers to Services

In addition to the problems of a fragmented service networks of medical care, general social services, special services for the aged, and mental health services, there are a number of reasons why ethnic elderly may not enjoy full access to mental health treatment.

Cultural barriers

Ethnic families are more likely to care for a mentally ill elder at home. Because of this practice, the caregiver is placed at risk for developing mental illness, particularly depression as their burden of caregiving tasks increases.

Ethnic families may have difficulty in acknowledging changes in behavior and cognitive functioning of older family member. This may be due in part to the make of the family and the importance supports which ethnic elder provide. "Many ethnic households include three generations. Ethnic elders are likely to provide psychological, social and financial support to family members and receive support from them. Because ethnic elders often have the roles of oral historical and final arbitrator in their families, changes in their ability to think, to plan, to understand, and to make reasonable judgments may be difficult for the adult children to acknowledge" (Baker, 1992, p.338).

Language barriers

Language problems hamper a significant portion of the minority elderly in trying to describe symptoms to providers of health services (Secretary's Task Force on Black and Minority Health, 1985). A large number speak English as a second language and many do not speak English. Many of the mental health facilities do not have staff who can communicated with elderly clients in their own languages. For services to be accessible and effective the must be delivered within an appropriate linguistic context.

Knowledgeable providers

The training of mental health professionals to meet the needs of minority elders has been problematic in at least two ways. There is a shortage of trained minority persons to work in the field and the existing curricula for mental health providers is inadequate to address the need of minority communities. Thirty percent of ethnic elders with at least two chronic medical conditions who are treated at outpatient medical clinics are estimated to have depressive illness (Ruegg & Swerdlow, 1988).

Elderly minority most move through the network of mental health, aging services and health services. Given that most elderly psychiatric patients have some chronic illness and many are significantly impaired or need some medical care on an ongoing basis demands service coordination and assessment of cognitive, emotional and behavioral functioning by primary health care providers.

Discrimination

There exists within communities of color a perception of inequity in treatment provided by the mental health system. A recent study reported that one out of five Black family members of mentally ill clients felt that they or their family member would be treated differently, presumably better, if they were White instead of Black. These perceptions may have a basis in fact. A recent study (Snowden & Cheung, 1990) reported "Despite equal access to supportive community services, and controlling for sociodemographics, previous hospitalizations, diagnosis, and time in program, Blacks were found to be hospitalized significantly more frequently than Whites" (p.351).

Financial Barriers

Income clearly affects the ability of ethnic minority elders to obtain necessary mental health care. It influences the timing and quality of health care that they receive. Older Blacks are among the most economically deprived groups in our society. In 1988, one out of every three Blacks 65 years of age or older was poor. The poverty rate for elderly Blacks is more than three times as great as for elderly Whites: 32.2% versus 10% in 1988. Elder Hispanics have high illiteracy and poverty rates (Sanchez, 1992) which tend to jeopardize their mental health.

The rising health care costs have placed minority elders in a predicament. Critical daily needs have forced them to compromise their mental health care. Because of the exorbitant health care cost and the absence of comprehensive insurance coverage, the elderly today spend the same proportion of their incomes on health care as was the case before Medicare and Medicaid were established 25 years ago (Villers Foundation, 1986).

In the mid-1980s, elderly Whites supplemented Medicare with private insurance more than twice the rate for the Black elderly population 69 versus 31 percent (U.S. Department of Health and Human Services, 1987). A subsequent report from the Nation Center for Health Statistics indicated that 79% of elderly Whites held private health insurance in 1986 compared to just 38.5% of elderly Blacks (U.S. Department of Health and Human Services, 1986).

Minority families are often unprepared for the changing needs of older mentally ill members. Dementia may initially require minimal supervision but gradually demand skilled care for which many minority families are financially unprepared.

Summary

As a Nation, we can provide accessible, culturally competent services to minority elders. As a group, they are likely to acknowledge symptoms but not necessarily attribute the symptoms to a mental illness, lack information about mental illness, avoid treatment because of stigma and discrimination, are unaware of the existence of outpatient therapy, lack transportation and view service as too costly.

Unless there is an increased and sustained effort to provide to elders and their families accurate information about mental illness, available outpatient treatment and treatment costs, and

active effort to reduce stigma within a cultural context; provide transportation or outreach services; increase in the number of persons trained to accurately diagnose the population, and the elimination of the perception and reality of discriminatory practices; millions of elders will go under served. Millions will suffer with treatable illnesses, families will undergo undue stress in their attempt to meet the need of a mentally ill family member without adequate supports, existing general and psychiatric services will be used inappropriately and cost for treatment will be more expensive.

Next steps in access

States are still the primary providers of mental health services. Few states have addressed the issue of differential service delivery. Federal agencies can encourage the development of comprehensive services at the local level which integrate principles of cultural competency. Federal and State agencies can encourage the development of a comprehensive mental health system which includes resources indigenous to the culture and local community (clergy, natural healers, fraternal and social organizations, tribal leadership and schools).

To address the lack of information about mental illness among the elderly and service providers to the elderly, Federal agencies can develop a clearinghouse and develop a program of public outreach to educate and inform the public regarding mental illness. Research Institutes can disseminate program treatment information in readily useable form. Moreover, agencies can increase training opportunities to develop programs to provide primary care givers with educational information regarding how to identify, accurately diagnose and appropriately refer for mental health treatment.

Partnerships between the Federal Government, States, providers, consumers, family members and advocates can be formed and strengthened to accomplish a number of goals such as expanding services; encouraging home visits for the delivery of outpatient mental health services, providing better access, coordination and distribution of information about services in the services networks for elderly persons, their families and caregivers. The partnerships can educate providers about mental illness; educating elders on health insurance options; improving financing through health care reforms and end discrimination in health care treatment.

These partnerships can develop data systems and disseminate results to improve knowledge base of availability and use of services. To address the needs of the family, the partnerships can develop social supports for mentally ill persons and their families who are particularly vulnerable to depression and burn out. They can increase the provision of consistent quality transportation service for elderly that meets their needs, thereby avoiding isolation and loneliness, and enhancing their opportunity to maintain active and independent lives.

Finally, access to appropriate services will require an education of the client population and their families about their treatment as well as mental health professionals and other health providers about mentally ill older adults, their problems, and the social context in which they live and seek services.

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STATEMENT OF MARIANNE SMITH, GEROPSYCHIATRIC CLINICAL NURSE SPECIALIST, ABBE CENTER FOR COMMUNITY MENTAL HEALTH SERVICES, CEDAR RAPIDS, IA

Ms. SMITH. I would like to also say thank you for the invitation from the Committee to be here today to speak with you all about the issues surrounding mental health care for rural elderly. I would also like to say, Dr. McCombs, I wish you would have gone last because that was a very powerful closing and you are a hard act to follow, as are the other presenters who have already spoken with you this morning. I would like to clarify; I am not a doctor, I am clinician. I have a masters degree; I am a clinical nurse specialist; I work in a practice setting; I don't hail from an academic environment. I come to you representing a mental health center that has been blessed with outside funding from the National Institute of Mental Health, the Administration on Aging, and our own Staff Division of Mental Health to try to develop an innovate service delivery model to provide services to rural elderly with mental and emotional disorders. So my background allows me to share a practice perspective with you.

The thing that I would like to emphasize about our rural elderly is that many of the problems are environmentally driven. They are the problems that plague rural people in general, in terms of economic hardship and lack of access to adequate mental and physical health care services, including a lack of health care insurance. Those problems are particularly pronounced for our elderly. In fact, it has led some to label elderly in rural settings as being at "triple jeopardy" because they are rural, they are poor, and they lack health care insurance. Those problems make the mental and emotional service needs of this group multidimensional and very complex, and their problems are often complicated by the fact that service systems are fragmented and uncoordinated in our rural settings.

As far back as 1978, the Panel on Rural Health of the President's Commission on Mental Health (PCMH) emphasized the unique mental health service needs of the rural population. I quote "Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression; by severe intergenerational conflicts; by restricted opportunities for developing adequate coping mechanisms for facing stress and for problem-solving; by an exodus of individuals who might serve as effective role models for coping; by an acceptance of conditions as being beyond individual control; and by fatalistic attitudes and minimal subscription to the idea that change is possible."[1] I regret to report that only modest progress has been made in meeting the needs of the rural elderly since that report was published in 1978. The lack of medical and social services in our rural areas increases the likelihood that correctable illnesses and sensory deficits will be identified and treated.

Despite the fact that the number or elderly residing in rural areas has grown at a disproportionate rate relative to the general population in our rural States, there are still too few mental health services and social services available for rural elderly. My own

[1] PCMH, 1978, V. III, p. 1164.

State of Iowa has the highest percentage of over-85-year-olds, and second highest percentage of those over the age of 65, in the country. That is characteristic of many of the States in the Farm Belt, including Nebraska, Minnesota, Missouri, and South Dakota. I think that advanced age and frailty are important to consider in terms of access to mental health services.

We know that many barriers exist to delivering services in rural areas, and I would like to talk about each one of those briefly. The observation that elderly are reluctant to accept services, even when they are available, is underscored by the observation in our rural areas that only 5 percent of the patients at community mental health centers and less than 2 percent of those served by private psychiatrists are elderly. I would like to ask "How do you utilize services that aren't there?" I think that in many of our rural areas observation that "elderly don't use services" has been used as a justification for not developing services that are adequate, accessible, and acceptable—and I would underscore the word acceptable.

When Leona Bachrach, she talked about services for the chronically mentally ill, she said that access really demands that services be, one, financially accessible, meaning they have to be affordable; people have to be able to pay for them. They need to be geographically accessible, meaning we have to be able to get to them or we have to be able to take them to people if that is needed. They need to be longitudinally accessible, meaning they have to be there across time; they can't "be here today, gone tomorrow." People have to know that the service is there, that it is reliable, and that it can be used. And finally, it has to be psychologically accessible to the person. I think that aspect of psychological accessibility is where we have really failed in terms of reaching our rural elderly.

When we look at psychological accessibility, one of the things we need to remember about mental health centers and mental health care in rural areas is that the services are typically clustered in the cities and urban centers of our rural areas. For instance, in my own community, the mental health center is based in a city of 160,000. Prior to the Elderly Outreach Project, which I was part of, "outreach" was simply the placement of a satellite office in a more rural part of our catchment area. However, satellite offices of this type classically are understaffed and sporadically staffed, and still require that the older person come to the mental health center, knock on the door, and say "Help me." We know that just simply isn't going to occur. So we need to be more innovative in the kind of services that we offer to our older adults.

The reliance on "traditional" models in mental health as I just described, has been one of the gravest deterrents to the utilization of services by rural elderly. Attitudes of mental health providers, who say, "Well, if they don't ask for services, then obviously they are not going to really benefit from them." Combine with beliefs that elderly are incapable of change (based on some of Freud's theory), and negative attitudes of elderly to interfere with science development and delivery. The aspect of stigma experienced by so many rural elderly is important to consider. We talked a little bit about the fear of institutionalization being one of the primary fears of older adults. I think that is a real life fear for rural elderly. In rural communities, jails are often used to contain mentally ill peo-

ple, and nursing homes in many, many cases have become the custodial prisons for the mentally ill rural elderly. In addition, family, community members, and health care providers alike believe that it is "natural" to be old and sad and to become senile, and, consequently, they accept those problems without looking for appropriate diagnosis and treatment.

Geographic barriers are also substantial. And I think that is the barrier that we most often think about when we're talking about access to rural elderly. I see geographic access as a big problem, but maybe not even as big a problem as psychological access. The financial crisis experienced by many rural hospitals and health care centers has resulted in fewer and fewer providers, which means longer and longer distances to travel to all kinds of services, including mental health. Geographical access is a particular problem for rural elders, many of whom are unable to drive and are very frail in health. Again, that refers to the over-85 population which is the most rapidly growing segment of older adults in our country. Even when special transportation services are available, lots of older adults resist using those services, complaining that they are both physically uncomfortable and, importantly, they are emotionally uncomfortable.

I think that in the future we need improved cooperation and linkage between agencies and services. An article published in 1987 by Barry Lebowitz, Enid Light, and F. Bailey observed that when mental health centers, aging services, and other health and human service providers build linkages and cooperative ventures and seek to develop and maintain a continuum of services from prevention to illness treatment, their elderly clients are better served. And I think that is the crux of what needs to happen in our aging rural areas. "No one agency, such as the AAA, the Area Agency on Aging, or the community mental health center should claim rural mental health as an independent service domain because coordinated health, social and psychiatric services, are required to address the mental health needs of older adults." That is a quote from Eloise Rathbone-McCuan from The Future of Aging in Rural America: Proceedings of a National Symposium (1992, p. 87). Likewise, the informal social support networks of rural elderly are inadequate to meet the often complex and multidimensional needs of this group, even though the involvement of this network is often critical to successful intervention with rural elderly. As Marilyn mentioned earlier, involvement of the informal caregiving network (usually family) is essential to effective treatment.

My observation is that there are often "ownership" problems between agencies in rural settings and maybe in other areas as well. Our Area Agencies on Aging have proven effective in delivering all kinds of crisis services and information and referral services, but few have opted to address mental health care if it draws them into the politically charged and stigmatized arena of psychiatric care. I think that goes back to the idea of stigma and is a very important issue. AAAs believe that the mentally ill older client is the responsibility of the community mental health center. The community mental health center, in tune, believes that the mentally ill older person is the responsibility of the aging service network; again, returning the onus of responsibility back to the AAA. As Mick ob-

served, in that kind of a service delivery atmosphere, the person often remains at home—unidentified and untreated. I believe we need more incentives to bring people together; incentives to bring the informal and formal service delivery systems together and to involve the primary health care providers who often identify elderly who are distressed, particularly in our rural areas.

I think we have established that there are effective service delivery models for rural areas but they need to be more widely replicated and they need to be supported by funding that allows them to do that. And in closing, I would like to offer a few words about the Elderly Outreach Project (EOP), in which I was involved as an innovative model of care for rural elderly. The EOP used nontraditional referral sources to identify elderly at risk for mental illness. The Outreach team provided in-home services, and connected those referred with other medical and social services. We were very effective in the 3 years of operation that we had outside funding. The funding ended in 1989. Between 1989 and 1992 we sustained that program of care, meaning that we kept it going beyond the time that we were grant funded, which is a big step. In the last year, and this is a very sad note in my opinion, the reimbursement mechanisms for Medicare and Medicaid and other kinds of private insurance have become so stringent that delivering in-home care is no longer possible. If we can't be reimbursed for the service, we can't provide it any longer. So I think reimbursement issues are a really critical issue, as well as methods for innovative and acceptable services to be replicated and sustained via improved cooperation between agencies and services.

Thank you.

[The prepared statement of Ms. Smith follows:]

Access to Mental Health Services in Rural Settings

Marianne Smith, RN, MS

Introduction

For many rural residents of this country the romanticized vision of a tranquil and prosperous lifestyle has been replaced by the realities of economic deprivation, inadequate housing and insurance, and unaddressed physical and mental health problems. This is particularly true for the elderly, who have been described by some as experiencing "triple jeopardy", that is, they are rural, poor, and without health insurance. Not surprisingly their mental health needs are complex and multidimensional, and are compounded by frequently fragmented, uncoordinated and inaccessible services. In 1978, the Panel on Rural Health of the President's Commission on Mental Health (PCMH) emphasized the unique mental health service needs of this population:

> Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression, by severe intergenerational conflicts, by restricted opportunities for developing adequate coping mechanisms for facing stress and for problem solving , by an exodus of individuals who might serve as effective role models for coping, by an acceptance of conditions as being beyond individual control, and by acceptance of fatalistic attitudes and minimal subscription to the idea that change is possible, (PCMH, 1978, V. III, p. 1164)

Regrettably, over the past 15 years only limited progress has been made in addressing the mental health and social needs of the rural elderly. The lack of medical and social resources in rural areas increases the likelihood that correctable illnesses and sensory deficiencies will remain undetected and untreated. Despite the fact that the number of elderly residing in rural areas have grown at a disproportionate rate relative to the general population there are still too few mental health and social services available in rural America. And, because many elderly are reluctant to accept such services even when they are available, care alternatives are often restricted to emergency or crisis intervention, or long-term institutionalization. Often, people remain at home uncared for -- especially the poor and frail.

Many barriers impede the effective delivery of mental health services to the rural elderly still exist. These include inadequate number of staff knowledgeable in psychogeriatrics, limited service delivery models, lack of economic resources, organizational, attitudinal and geographic barriers, and the lack of coordination among mental health, medical, aging, and human service providers whose services all have been affected by the rural economy. Please let me expand briefly on each one of these barriers.

Reluctance to Accept Services

Some have observed that elderly are reluctant to accept mental health services, even when they are available. Although 15 to 25% of those over the age of 65 years are believed to suffer from significant mental health problems, only about 5% of patients at community mental health centers and less than 2% of patients seen by private psychiatrists in rural settings are elderly. However, I ask, "How does one use what isn't there?" Are we using this "observation" regarding non-utilization of services as a justification for failing to provide adequate, accessible, and acceptable services?

Access Dimensions: Financial, geographic, longitudinal, psychological

As Leona Bachrach noted, in regard to services for chronically mentally ill individuals, access to services is multidimensional. Services need to accessible at several levels. First, they need to be financially accessible. That is, they must be affordable so that people will use them. Second, they need to be geographically accessible. They must be provided where the people who need them are located. Third, they must be longitudinally accessible, meaning that they have to be there to help people across time. They can't be "here today and gone tomorrow" or people won't trust them. And finally, they must be PSYCHOLOGICALLY accessible, meaning that they must be acceptable to the person who is using them. And with all of the problems created by the stigma of mental illness, particularly among the elderly, the aspect of psychologically accessible services is of paramount importance to consider.

Psychological access means that the older adult must feel "okay" about accepting the service. Unfortunately, we also know that many rural elderly are very fatalistic in their perspective of the world (as noted in the President's Report earlier), that they feel very stigmatized about being "mentally off" and are extremely fearful of being institutionalized. The fear of institutionalization, which I believe is even more pronounced among rural elders than urban ones, is often a real life fear. Because services are so limited, and rarely used, in many cases, the older adult isn't identified or treated until the problem has reached crisis proportion, and that crisis often results in their placement in an nursing home. In rural setting, jails are often used to contain mentally ill people, and nursing homes have become the "custodial prisons" for mentally ill elderly in rural settings. Regrettably, this phenomenon is reinforced by the rest of the community, including families, family physicians, and other health care providers, who may believe that it is natural to become "old and sad" or "senile." And as a result, they fail to seek out appropriate care and treatment for the older person.

Lack of Trained Professionals

Lack of appropriate, accessible, and acceptable mental health services is also complicated by the lack of mental health professionals trained to work in geropsychiatrics in our rural areas. In our sparsely populated rural settings, we often have difficulty attracting trained mental health professionals of all types, let alone ones who have sub-specialized in geriatric care, because they are low revenue-producing. Thus, the financial and personnel shortages to plan, implement, and sustain geriatric mental health programs in rural areas are interconnected with the larger mental health picture in Rural America. Even when psychiatric nurses and social workers are available to treat elderly, the lack of diagnostic, medication, and consultation services by psychiatrists interferes with third party reimbursement and comprehensive care.

Organizational Barriers

Other problems are created by the actual location and service delivery model of the mental health services being offered in rural America. In most situations, the mental health center (MHC) is located in an urban center within a rural catchment area that serves several counties or districts. In the traditional model of care, in which patients are expected to seek out services on their own behalf (which we know elderly don't do), "outreach" services mean that the MHC has a satellite clinic in an outlying area. Unfortunately, these "outreach" clinics are minimally and sporadically staffed. Likewise, this model still relies on the client coming to the center, a matter that defies "psychological access" for many rural elderly.

These problems are further compounded by mental health providers who view older adults as "incapable of change," and hence as unworthy of much time or attention. These negative and stereotypical attitudes often result in "explanations" that sound something like this: "Well, if the older person really wanted help, they'd ask for it. The fact that they don't present themselves at the mental health center, asking for assistance, means that they can't really be very serious about 'working' on their problems. And given our current economic stresses and scarcity of human and materials resources, no one is going to go "look" for more business."

Geographic Barriers

As Bachrach noted, geographic access is of primary importance to consider, particularly with rural elderly. The financial crises experienced by many rural hospitals and health care centers has resulted in fewer and fewer providers. In turn, that means longer and longer distances to travel to services of all types, including mental health. Geographic access is a particular problem for rural elders, many of who are unable to drive because of physical frailty or sensory deficits. This is of most concern for our "oldest-old," the group over 85 years of age which is the fastest growing segment of the elderly population. In many rural states, like my own, those 85 and older make up a disproportionately high percentage of the population. For example, Iowa has the highest percentage of those aged 85 years and older, and is tied for the second highest percentage of those aged 65 and older. In other words, the problems of the physically frail are of great concern to us, particularly when we examine impediments that related to geographic access.

As I mentioned earlier, mental health services in rural states are usually clustered in urban areas, including those "outreach" services offered at satellite offices. That means that many rural seniors will need to travel long distances to see a mental health professional, a problem that is frequently compounded by bad weather, adverse road conditions, and lack of public transportation systems. Together these factors (physical frailty, long distances, bad weather and roads, etc.) combine to reduce access to services and increases difficulties in coordination and communication relating to care. Even when special transportation services are provided outside the county seat, may elderly resist using the service, complaining that theses services are both physically and *emotionally* uncomfortable.

Lack of Coordination and Cooperation Among Agencies/Providers

Of all the barriers to providing mental health services to rural elderly, the lack of coordination among health, mental health, and aging and human service providers is perhaps the most distressing. In 1987, Lebowitz, Light, and Bailey described a survey of community mental health centers across the county. The concluded that when mental health, aging services, and other health and human service providers build linkages and cooperative ventures, and seek to develop and maintain a continuum of services from prevention to illness treatment, their elderly clients are better served. In brief, better cooperation among providers is clearly needed.

As noted by Rathbone-McCuan (1992), in The Future of Aging in Rural America: Proceedings From a National Symposium,

> "No one agency, such as the AAA [Area Agency on Aging] or community mental health center should claim rural mental health as an independent service domain because coordinated health, social, and psychiatric services are required to address the mental health needs of older adults" (p. 87).

Likewise, the informal social support networks of rural elderly are inadequate to meet the often complex and multidimensional needs of this group, even though the involvement of this network may be essential to successful interventions with rural elderly.

Unfortunately, cooperation and linkages between mental health, medical, and aging service providers has been slow to develop. In too many cases, this a reflection of "ownership" questions. That is, who is really responsible for providing mental health services to older adults.

Although Area Agencies on Aging (AAAs) have proven to be very effective in providing a range of services to older adults, from information and referral to crisis intervention, few have opted to address mental health care if it draws them into the politically charged and stigmatized arena of psychiatric care (Rathbone-McCuan, 1992). Too often the AAA believes that the mentally ill older adults is the responsibility of the mental health center (MHC), while the MHC views elderly people, mentally ill and otherwise, as the primary responsibility of the aging service network. This belief has been reinforced by legislative changes and severe budget cuts that have reduced mental health initiatives for special populations like the elderly.

Limited Service Delivery Models

A final challenge to the delivery of mental health care to rural elderly relates to the limited number of service delivery models that have been developed and evaluated. However, it is with deep regret that I report that the lack of effective models isn't even as disappointing as the fact that models that have proven to be effective have been disabled by their own state policy-makers and legislatures. I offer the Mental Health of the Rural Elderly Outreach Project (EOP) as an illustration of a federally funded project that has all but disappeared because of the failure of our state system to approve reimbursement for in-home services. The EOP, which was funded between 1986 and 1989 by funding from the National Institute of Mental Health, the Administration on Aging, and the Iowa Division of Mental Health, was an innovative model. We used community gatekeepers to identify older adults in need of mental health services and then provided those services in their home, rather than expecting them to come to the mental health center. The model was believed to be effective, both in terms of reaching people who needed assistance as well as in cost. At the end of the three years, the center's administration made a commitment to subsidizing the outreach service to elderly so that it could continue. The Center instituted a policy of "payment when appropriate," which

left the decision of whether to charge, and when to charge the older person within the judgment of the individual outreach therapist. However, the goal was to generate even a modest amount of revenue via third party reimbursement to help maintain this much needed component of care for older adults. Unfortunately, the outreach service has nearly ceased because of restrictions on the provision of in-home mental health services. That is, Medicare, Medicaid, and other private insurances refuse to reimburse the MHC for needed mental health services simply on the basis of the location of the service. Initially, the outreach team was most concerned that elderly clients may resist paying for in-home services, particularly when they didn't seek them out on their own (e.g., someone referred them to the team and they were offered services). However, this concern has proven to be much more "workable" than the question of reimbursement for services provided outside the physical structure in which the Center is house. In spite of the fact that the model had proven effective, the Center had a commitment to continuing the service to those who needed it, and older adults were willing to let us bill for the services provided, the failure of our system to reimburse for those services has nearly destroyed "real" outreach services to older adults in our community.

Summary

In summary, many barriers stand in the way of providing effective, affordable, acceptable mental health services in rural areas: 1) the lack of trained geropsychiatric professionals to work in our rural areas, 2) the lack of services that extend beyond the traditional models of care in which outreach is simply a satellite office, 3) geographic barriers that are compounded by the physical frailty of so many rural elders, 4) feelings of stigma associated with mental illness that demand services that are "psychologically accessible" to older people, 5) negative and stereotypical attitudes and beliefs about aging held by the rural community, including older adults themselves, 6) lack of coordination and cooperation between mental health, medical, and aging service networks, and 7) reimbursement systems that allow older adults to gain financial access to appropriate mental health services. Increased mental health education, geropsychiatric training programs, research regarding service delivery models, and direct funding of mental health services provided to rural elderly are all needed.

Although time limitations prohibit lengthy discussion of nature of these needs, I would refer interested parties to the proceedings of the conference "Health and Aging in Rural America: A National Symposium" which will be published by the Center of Rural Elderly, University of Missouri-Kansas City and as a book by Springer Publishing this fall. The expanded version of a chapter contributed by Dr. Kathleen C. Buckwalter, myself, and Catherine Caston and which details the mental and social health needs of rural elders is included for your review. Likewise, copies of manuscripts describing the innovative service model in which I was involved, the Mental Health of the Rural Elderly Outreach Project, are included for your consideration.

Mr. RICKARDS. That was excellent. I want to thank the panel for not only excellent statements, but for drawing out critical issues that still remain to be addressed. Each of you in your presentations drew upon research that has been conducted. I am really struck by the observation that the more we study, the more we know how much further we have to go to fully address the mental health needs of older adults. Thank you for bringing that out.

I wanted to shift just slightly to something that each of you alluded to, but only partially spoke to—the training of people who are going into the field. One of the issues that is evident from all of the speakers today is that there are certain competencies and specialties that are particular to providing mental health services to an aging population that may overlap, but often are very distinct from, other populations. Where are we regarding the training of professionals across various specialities in providing mental health services to an older population, and in providing culturally competent service to a broad spectrum of minority elders?

Dr. MCCOMBS. I would like to address that by addressing the appropriations for training in the Center for Mental Health Services budget this year which happens to be zero. So in terms of clinical training of the types of individuals we would like to come into this area, I think we have already addressed that in our appropriations.

Dr. RABINS. I would just like to add to that. I think that is one major barrier. Another barrier is that the people who are responsible for training in many fields—medicine, social work, nursing—are people who themselves are not experts in aging. They are not old enough to see the need and when they were young they were not trained. So we are really getting squeezed on many ends. There are not the financial resources to support it and there is really not the knowledge base among educators who are in power now to perceive the important issues that we're talking about. It is a major problem I think.

Mr. SMYER. Larry, could I just add one note. You didn't include paraprofessionals in your litany but I would urge you to expand that.

Mr. RICKARDS. That is an important addition.

Mr. SMYER. Because particularly for example in nursing homes and also in many rural areas, it is the paraprofessional providers who are the frontline workers and, again, we need to kind of leverage the professional expertise that we have to extend it to get those people to be more effective mental health care providers as well as physical health care providers.

Mr. RICKARDS. There is someone in the audience who seems very interested in speaking. Please tell us who you are.

GRETA KRAHN, AMERICAN COUNSELING ASSOCIATION

MS. KRAHN. Thank you and I will try to keep this brief. My name is Greta Krahn and I am here representing the American Counseling Association. I would just like to mention a little bit of hope here in what seems to be an area where we need some hope in training professionals to work with the mental health issues of aging. The American Counseling Association and in particular the National Board for Certified Counselors has a specialty in certified gerontological counseling. We have developed a series of mental health

training competencies and that information is available through the American Counseling Association and we're encouraging training programs that are training professional counselors to infuse gerontological counseling competencies in their training programs in an effort to train professional counselors and other mental health professionals to be aware of the issues of aging and train them how to work with that population. Just a little but of hope.

Mr. RICKARDS. Thank you very much. We could really spend much more time with this. I really hate to have to cut off our discussion because of time. We're just scratching the surface of these issues. Thank you for your statements and comments.

Ms. COLEMAN. In putting together the forum, the organizers decided that it was really important to understand how mental health services are reimbursed. I think that all of today's speakers have touched on a bit on the methods of payment. Dr. Gary Gottlieb is an authority on what mental health services are or are not reimbursed. He has a unique vantage point, because he is a psychiatrist as well as an MBA. Dr. Gottlieb will present an historical perspective to reimbursement of the mental health services.

Dr. Gottlieb.

STATEMENT OF GARY GOTTLIEB, M.D., UNIVERSITY OF PENNSYLVANIA

Dr. GOTTLIEB. What happened to the rest of the panel here with me?

Ms. COLEMAN. We heard that you were so great that you could do it all by yourself.

Dr. GOTTLIEB. They are all going through my slides on the outside.

Thank you all for staying this long. I will conform to everybody else's time requirements, not to the original ones planned for this, so that we can let everybody go and still smile.

As you are aware, older people represent about 12 percent of the American population but they consume greater than 30 percent of all health care in the United States. Now that's in sharp contrast to some of the data you've heard today in regard to the way that older adults consume mental health services. They consume about 2 percent of all private psychiatrists' and psychologists' time in the community, somewhere between 4 and 7 percent of the community mental health services, depending upon where you are and where the data are from, and about 9 percent of inpatient psychiatric services. Even the skew to the most intensive services are somewhat disturbing.

Some of this is because of Medicare and some of it is because of how thorny this is as a policy issue. You need to be empathic about the people who usually live on this side of this stage because I think to some extent dealing with older adults and developing a policy that covers the entire geriatric population is a very, very difficult issue. Older adults are a diverse group of people, they represent ethnic minorities as well as individuals who are not ethnic minority, and there is tremendous variation in sociodemography. For example, about 20 percent of older adults live at or near the poverty level. At the same time, about 13 or 14 percent of older adults have net worth in excess of $250,000. How do you as a pol-

icy group make a determination to what covers everybody and what is appropriate in that regard? This is the only group that has been set aside as a single group that has an entitlement program associated with it and it is very hard to synthesize that in a way that is very pleasing to all Americans all the time, particularly as the ratio of younger Americans to older Americans starts to diminish and that group of population that theoretically has been determined to be supportive of those entitlement programs may have different desires in regard to the outcomes. So there is a reasonable burden.

The other issue that was very strange is that when Medicare was developed in 1965 a whole bunch of other things were going on. People were probably sitting in rooms like this saying the same things we we're saying, and that is this is an incredibly exciting time, this is a landmark era in regard to health services because for the first time the Government was going to play a major role as a third-party payer for many services in terms of health care on the Medicare side and for indigent Americans through Medicaid. At virtually the same time, coincident, a little bit beforehand, we started to focus on mental health services with the Community Mental Health Center Act. It seems like, just as was mentioned by Ms. Smith just moments ago, on the one hand there was the expectation on the part of those people who were advocates of the Community Mental Health Center Act that issues related to mental health for older people would be taken care of by Medicare; those who were taking care of Medicare and changing the Social Security acts figured the Community Mental Health Center Act and the institutionalization and the money left over in that regard would deal with issues related to mental health services. And therefore, to some extent, Medicare left mental health services in the breach.

In that regard as well, the institutionalization created a defensiveness on the part of the Federal Government. Remember, those people who were institutionalized in large, large numbers through the 1950's and into the early 1960's were the responsibility of State governments. Well if, in fact, those people represented most people who needed psychiatric care, if that stuff was going to come out of either the Community Mental Health Center Act or out of Medicare, all of a sudden there was going to be cost shifting. The State government was going to be throwing all of that burden onto the Federal Government and the Federal Government built some intensive barriers to prevent that from happening.

As Dr. Lebowitz and Dr. Rabins pointed out just moments ago, or many moments ago as this has extended a little bit longer than you expected, to some extent these disorders are disorders that occur over a lifetime. They are not disorders always that occur with a single treatment and then forget about this for the rest of your life as one does with some, and only a very small number, medical disorders, largely infections. As Dr. Lebowitz pointed out, and I really need to support this notion and it was supported by Dr. Rabins, I would say that the treatment for a number of psychiatric disorders is more specific than any other treatment that we have in medicine perhaps except for the use of antibiotics for a number of bacterial infections, particularly treatments for major depressive

disorders, anxiety disorders, sleep disorders, and psychotic conditions, but particularly depression.

In that regard, the way that Medicare was developed to focus on acute illness again has a problem in terms of mental disorders and providing appropriate service delivery. The design of Medicare is to cover acute illness. The inpatient component of it or Part A is focused on essentially removing risk for catastrophic illness. Essentially, there are spells of illness that are defined and for a benefit to start over again or not to reach into one's lifetime reserve days essentially requires about 60 days out of being treated for acute illness. That is extremely important.

Additionally, there is very little provision for any kind of long-term care in the Medicaid system. Most of long-term care is paid for either out-of-pocket or by becoming medically indigent or being indigent ahead of time and paid for out of the care for people who are medically indigent in the Medicaid system which is split about 60–40 between Federal and State sides. So essentially there is very little provision in this system for any kind of long-term care. The only provisions for services outside of hospital are in skilled nursing facilities for people who have been in a hospital for a period of at least 3 days in the month ahead of the time that they needed to get some kind of rehabilitative care in a nursing home and only for a limited time period, and some in-home services which are also vigilantly controlled in terms of their adequacy. They have been improved but still, again, vigilantly controlled.

There are essentially two components to Medicare and they have changed a little bit—I am supposed to talk about past, present, and future—and they will change, of course, as well and that is why Mrs. Gore left—was hopefully to establish how they will change. I am inspired by the work that she and Bernie Aarons have led in regard to their holistic appreciation of these needs. But there are two components. There is Part A which is hospital coverage that everybody with Medicare gets. Essentially, that hospital coverage, as I mentioned before, is designed for acute illness. There are spells of illness and the first 60 days are covered. Then there are co-pays for days 60 through 90 and days 90 through 150 but you can only use days 90 through 150 unless you are out of a hospital for 60 days in between spells of illness once in your lifetime. Those are called "lifetime reserve days" and that means if you have a catastrophic illness you are in big time trouble.

Second, as I mentioned before, there are limitations in the skilled nursing and home care. It was felt in the early 1980's particularly by the Reagan Administration that Medicare was big time trouble for the budget because of hospital care and the costs on the hospital side needed to be controlled. So as a result of the Tax Equity and Fiscal Responsibility Act of 1982, known as TEFRA, essentially there was a new method for so-called prospective payment of hospitals in terms of the care of older adults and other Medicare recipients in regard to their need for acute hospitalization. It is not really prospective, it is really a case-based reimbursement. If it were prospective, you would pay in advance for a whole population like a capitation payment and then you would take risk for a whole bunch of lives, sick or well, and you would figure out how to care for those people and you would then design some continuum of care

to prevent them from needing to be in the hospital. Nothing prospective about it; it is a retrospective reimbursement that is based upon sums that are derived prospectively or in advance that are based upon a theory that some mix of diagnosis can tell you how much people are likely to consume when they are in the hospital.

If you apply that to medical diagnoses, it probably explains about 30 to 35 percent of the variance in utilization. If you apply it to psychiatric diagnoses, it is between 5 and 11 percent. So as a result of advocacy from some of the people who are here in this audience or their predecessors or their antecedents or their forebearers, and as a result of wisdom on the part of these chambers, to a great extent psychiatry and rehabilitation services were waived for the application of DRGs to reimbursement except when those services occurred in nonspecific units. So if I admit you on a psychiatric diagnosis to a so-called "scatterbed" of a general hospital, I am still reimbursed with a DRG for one of those mental health or substance abuse diagnostic categories in which you fit and there is really no fit between the payment mechanism and what it is that I am doing with you. In some years it has been established that a substantial component of inpatient psychiatric care in fact exists in those scatterbeds. In fact, the first year in which it was examined, 1984, which was the first full fiscal year after the implementation of TEFRA, I think 46 percent of all psychiatric inpatient care occurred in scatterbeds and probably there remains a substantial component that is in those beds.

But what replaced that were caps on reimbursement. Psychiatric care and inpatient settings would still be reimbursed on the old cost-based method but there would be a cap that was based upon utilization in that facility for the first full fiscal year after 1983. That was before there was much technology that was really derived or evolved related to understanding diagnosis in mental health disorders in the elderly, largely attributable to the efforts of the NIMH Aging Branch and the National Institutes on Aging, two of those heroes in doctors Cohen and Lebowitz really should be recognized in that regard. But a lot of the technology in terms of diagnosis, treatment, understanding the team approach to that population, the ability to use ECT safely in that population, also a lot of the shifting from people who had mental diagnosis in medical settings rapidly into the psychiatric diagnostic treatment arena had not occurred as well. Therefore, the caps that were set were probably unrealistic to those places that now provide the state of the science or the state of the art in appropriate treatment. Additionally, as one raises consciousness in regards to the needs of that population, those caps become unfair as well and therefore many hospitals have created substantial barriers to the admission of older adults to general hospital psychiatric settings because they are likely to be big time losers.

Also, Medicare still has a limitation that theoretically protected the Federal Government from getting involved with those people who used to be in institutional settings. And that is reimbursement for people who are in free standing psychiatric hospitals is limited to 190 days under Medicare per lifetime. Now think about this, as you have extended life and you have mean life expectancy and once you reach the age of 65 your life expectancy on average I think is

about 12 years at least and as you reach 75 again you have extended life expectancy. If you in fact have a recurrent bipolar affective disorder or a recurrent major depressive disorder and you happen to have a few of those episodes in late life, you are denied continuity of care if you had received that care in a specific free-standing institution or, if you are in a rural setting, the only place that may provide specialty mental health service may be one free-standing institution that happens to be in your community or somewhere near it and therefore the likelihood that you will be able to get inpatient care diminishes remarkably as a result of that lifetime days limitation. There is no lifetime days limitation for anything else under Medicare except that.

Under Part B, Part B is the supplementary medical insurance, it is elective but about 97 percent I guess of Medicare enrollees chose to pay the premium for Part B. Essentially, there has been an evolution over time but if you say that there is stigma in the culture, if you say that there is stigma in community, there is stigma essentially institutionally and governmentally imposed because mental health services are treated quite differently than general health services and that is reinforced by essentially Part B under Medicare. From 1965, from the advent of Medicare, until 1987, essentially services for professionals who provided ambulatory mental health services under Part B were limited to 50 percent payment of a total of $500 of reimbursement or a total of $250 of payment per annum. Okay? That's my metroliner fare roundtrip today, the cabs to get back to and from wherever it is I am going, my parking, and then I have about two-thirds of what the Government would have been willing to pay up until 6 years ago.

As a result of both OBRAs 1987 and 1989, there has been substantial improvement in regard to overall reimbursement and now in fact from a generosity perspective Medicare is as generous as any community or commercial provider in terms of reimbursement. That is to say there is no annual limitation in terms of number of visits for ambulatory psychiatric, psychological services. There is direct reimbursement for psychologists and direct reimbursement for social workers as well as physicians but not direct reimbursement for nurses except in some rural settings and not direct reimbursement for counselors under Medicare. There remains 80 percent reimbursement with a 20 percent co-pay for consultations, for psychological testing, for inpatient care. So there is still a perverse incentive to some extent on the inpatient side.

Additionally, the stigma that you mentioned before and clearly the discrimination from a financial perspective is intensified here with a 50 percent co-pay. As you mentioned just a moment ago, Dr. McComb, it is 3 to 1 caucasian to African-American in terms of affordability of Medigap policy and the wisdom of the Federal Government has improved Medigap policies as of this year that they now pay the other 50 percent co-pay in regard to psychiatric services. But we studied the primary service area of the University of Pennsylvania Medical Center this past month and looked at our activity over the past 3 years and saw that only 17 percent of that population, which is largely African-American, in fact has Medigap insurance because of its incredible expense. And therefore those people have to pay the other 50 percent co-pay. Remember, this is

not the meanness of the psychiatrist, the psychologist, or the social worker; it is fraud and abuse to automatically write off co-pays. The purpose of co-payments are theoretically to prevent what insurance companies call "moral hazard", that's a funny term for insurance companies to use.

Which essentially refers to the notion that if you have insurance, you will use it. And therefore if somebody who is poor has Medicare and it covers psychiatric treatment, they would use it, God forbid, and therefore from that perspective they would overuse the insurance. And to some extent some of the experience on our part as mental health providers in the past with very generous policies has unfortunately supported that notion and therefore it is essential that we become more specific with interventions and be able to control utilization as well.

So essentially there has been a gradual increase; it went from $250 to $450 in 1987, to $1,100 in 1988, to unlimited in terms of the outpatient cap now. However, there has been a major change in the way that the fee schedule affects reimbursement for psychiatric disorder as of the Omnibus Budget Reconciliation Act of 1989. As a result of the implementation of the Resource Base Relative Value Scale underwritten fee schedule, or the RBRVS—look, I didn't really say any of the other abbreviations, I didn't get to use my slides, so therefore I do get to say RBRVS.

And I could probably RBRVS backwards right before I'm over the time limit. There has been to some extent a reduction in reimbursement in many densely populated geographic distributions of mental health service providers for older adults. Essentially, if the purpose of RBRVS was to theoretically shift reimbursement from procedure-based medicine into cognitive-based medicine, I guess that psychiatric and psychological services are cognitive based, at least that has been my impression. However, there has been an overall reduction in reimbursement particularly for heavily used procedure codes in urban settings—in New York, Miami, Philadelphia, and on the West Coast where the largest concentration of these providers live. And while the total reimbursement shows a slight increase and somewhat favorable for mental health services, there remain substantial disincentives. Additionally, some of the somewhat capriciously written rules written by the medical directors of third-party administrators which have changed in fact the intent of the RBRVS have affected mental health services more adversely than others. Those include the inability to bill for two procedures on a single day only for mental health service providers and not for any other providers; additionally, limitations in reimbursement for nursing home visits which also create a disincentive.

Where are we moving from here? Well, there are incentives to move toward a managed care model on the Medicare side. Whether or not President Clinton, Mrs. Clinton, and Mrs. Gore are successful in terms of health care reform, clearly there is increased penetration in managed care as you move across the United States from the West Coast, and I guess Minnesota is on the West Coast if you look at the penetration of managed care, to the East Coast. And in those marketplaces in which there is greater than 40 percent penetration of managed care, there is a substantial component of at risk Medicare HMO management. At the present time, there has been

no real standardization of the way that mental health services are provided in those entities. There are extraordinary incentives to substitute highly skilled, well-trained mental health providers who are licensed or accredited with untrained and usually unsupervised providers at an average essentially of somewhere between $8 and $14 an hour. As a result of that substitution, those providers are able to profiteer on the mental health component. And even if benefits to some extent become—if there is parity in terms of benefits as was described by the Senators and by Mrs. Gore as an overall objective, if in fact those are lumped in a capitation and there is no regulation as to how they are to be employed, it will be tremendously problematic in regard to providing those services.

I see managed care as an incredible opportunity. It is the first opportunity to essentially provide incentives for continuum of care. It provides incentives for capitating the entire spectrum of services—partial hospital service, community residential care, substituting for overutilization of inpatient services, providing ambulatory care that is thoughtful and reasonable, additionally to provide services within nursing homes. To substitute nursing home services for hospital care when it is appropriate to reduce that utilization. It is a wonderful opportunity but it has to be meted out in an appropriate fashion so that those people who can in fact recognize and accurately treat those disorders in fact have access to those capitation dollars.

Thank you very much.

Mr. RICKARDS. I want to thank you for your statement. I really very much appreciate your analysis of the discrimination against the financing of mental health care and areas for health care reform that could benefit older persons.

In the interest of time, I will not ask questions. But I do want to thank all of our speakers for taking the time to lay out the issues as they see them. I think we have all learned from what we heard today. I also want to thank the Committee for having invited us and for their hard work putting this forum together.

If anyone in the audience has vital questions that they would like addressed by the presenters, I think we have an opportunity to include those in writing. If you would care to reflect and to submit some questions, please feel free to do so. Again, thank you very much for coming.

[Whereupon, at 12:10 p.m., the forum was adjourned.]

APPENDIX

Mental and Social Health of Rural Elders

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This paper was prepared as the result of the invitational symposium,

"Health and Aging in Rural America:

A National Symposium"

co-sponsored by

The National Rural Health Association

and

Center of Rural Elderly,
University of Missouri-Kansas City

September 13-15, 1992
San Diego, California

Official proceedings of the conference will be published in the future.

Mental and Social Health of the Rural Elderly

Kathleen C. Buckwalter
Marianne Smith
Catherine Caston

INTRODUCTION

For many rural residents of this country the romanticized vision of a tranquil and prosperous lifestyle has been replaced by the realities of economic deprivation, inadequate housing and insurance, and unaddressed physical and mental health problems (Norton & McManus, 1989). This is particularly true for the elderly, who have been described as experiencing "triple jeopardy", that is, they are rural, poor, and without health insurance (Rowland & Lyons, 1989). Not surprisingly their mental health needs are complex and multidimensional, and are compounded by frequently fragmented, uncoordinated and inaccessible services. In 1978, the Panel on Rural Health of the President's Commission on Mental Health (PCMH) emphasized the unique mental health service needs of this population:

> Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression, by severe intergenerational conflicts, by restricted opportunities for developing adequate coping mechanisms for facing stress and for problem solving , by an exodus of individuals who might serve as effective role models for coping, by an acceptance of conditions as being beyond individual control, and by acceptance of fatalistic attitudes and minimal subscription to the idea that change is possible, (PCMH, 1978, V. III, p. 1164)

Regrettably, over the past 15 years only limited progress has been made in addressing the mental health and social needs of the rural elderly. The lack of medical and social resources in rural areas increases the likelihood that correctable illnesses and sensory deficiencies will remain undetected and untreated. Despite the fact that the number of elderly residing in rural areas have grown at a disproportionate rate relative to the general population (Longino, Wiseman, Biggar & Flynn, 1984) there are still too few mental health and social services available in rural America. Nor is there a true continuum of services from prevention to death available in most rural settings. And, because many elderly are reluctant to accept such services even when they are available, care alternatives are often restricted to emergency or crisis intervention, or long-term institutionalization. Often, people remain at home uncared for -- especially the poor and frail.

The farm crisis of the 1980's brought the need for more comprehensive mental health care to the attention of the public, service providers, educational institutions, and policy makers (Stuve, Beeson, & Hartig, 1989). And yet many barriers that impede the effective delivery of mental health services to the rural elderly still exist. These include inadequate number of staff knowledgeable in psychogeriatrics, limited service delivery models, lack of economic resources, organizational, attitudinal and geographic barriers, and the lack of coordination among mental health, medical, aging, and human service providers whose services all have been affected by the rural economy (Buckwalter, 1990).

The purposes of this paper are to provide an overview of geriatric mental health services in rural America, including examination of the need for services, obstacles to delivering those services, costs and service provider issues, regional and cultural variations, factors that influence mental health services to the rural elderly and innovative programs that have successfully reached the rural elderly. Research, policy, educational and program development issues are also identified.

The paper begins with a brief overview of the most common mental health problems among the elderly: depression, suicide, alcoholism and dementia. Following a brief historical overview of mental health treatment in this country and characteristics of the mental health system, barriers to care of particular concern to the rural elderly are reviewed. The important role of informal networks and social support is examined next, followed by an overview of models and characteristics of successful services, highlighting rural outreach models. Public policy, legislative trends and related issues are explored with attention to federal laws relevant to geriatric mental health. Finally, research challenges in rural geriatric mental health are set forth. The paper concludes with a list of research, education, service and policy needs that flow from the information presented.

OVERVIEW: MENTAL DISORDERS IN THE ELDERLY

The elderly are at somewhat greater risk than younger age groups for the development or recurrence of mental health problems, although there is no empirical base from which to conclude that the distribution of psychiatric disorders is any different among the rural elderly than older adults residing elsewhere. Both functional and organic disorders increase with age, and the social conditions under which the elderly live can exacerbate stress and emotional problems (Intermill & Rathbone-McCuan, 1991). Approximately 15-25% of people over the age of 65 are purported to suffer from mental illness or emotional distress that impacts on their quality of life. Among the most common psychiatric disorders of later life are depression and dementia, which are also the most common diagnoses treated in two rural outreach programs for the rural elderly (Buckwalter, Abraham et al, in press). Additionally, suicide among the elderly is a grave concern, particularly for those elderly who lack social support and are isolated, as rural elders so often are. A fourth concern, one that is often overlooked or denied because of societal attitudes about older adults, is alcohol abuse. Each of these is discussed briefly to provide a framework for understanding some of the more common challenges to the mental and social health of rural elders.

Depression

As many as 15% of community dwelling elderly and 50% of frail medically compromised elderly residing in institutions suffer from depression (Blazer, 1989). The elderly suffer from primary depressions that occur for the first time in later life, from cyclical recurrence of depressive episodes throughout the life span, and are particularly vulnerable to secondary depressions whose etiologies include physical illnesses such as cancer and stroke, and from the side effects of commonly prescribed medications such as antihypertensives and analgesics.

Community surveys of the prevalence of depression among the elderly (mostly done on urban or suburban samples) have yielded widely differing estimates, ranging from 14%-44%. Studies comparing symptom and prevalence rates among rural and urban elderly have been equivocal. Murrel et al. (1983) found significantly more depression among rural men than urban men, and no differences for women, a finding that was not supported by Comstock and Helsing (1976). To complicate the picture further, recent research suggests that the rural elderly may have different prevalence rates and correlates for depression than is commonly reported in the literature. For example, a study of N=3159 non institutionalized older adults residing in rural counties found low prevalence of significant depressive symptomatology (9.0%) as well as clinical depression (2.9%). Gender differences were noted for depressive symptomatology, but not for levels of clinical depression. The data also suggest that those rural elderly who live alone and have lower incomes are most at risk for depression (O'Hara, Kohout, & Wallace, 1985), and point to the critical role of social support, higher education level and married status in lowering the risk for depression in this population.

In another study analyzing the mental health outcomes of the elderly in response to economic stress in rural areas (Hoyt, Redmond & Kundrat, 1987) the researchers did not find higher levels of psychological distress among the elderly after controlling for differences in economic stress, marital status and health gender, although mood tone and zest had significant negative relationships with age, and significant declines in measures of well-being were reported. Thus it appears that studies of affective illness in rural elderly populations offer conflicting findings, and the area deserves more investigation before policy decisions can be made and effective interventions implemented.

Suicide

As Osgood (1985) noted, "Although suicide in the elderly represents a major social problem, it has been virtually ignored in the United States. Attention has consistently focused on adolescent suicide, betraying our culture's emphasis on youth and devaluation of the aged" (p.xiii). Elderly white males have a higher suicide rate than any other age, gender, or race category (Osgood & McIntosh, 1986). Analysis of suicide rates by age indicates that they are largely accounted for by persons over the age of 75. In fact, the suicide rate for white males over age 75 increased from about 46 to 60 (per 100,000) during the period between 1981 and 1986, whereas the rate for white males in the 65-74 year old category grew from 30-38 (McCall, 1991), compared to rates for the general population of about 12 per 100,000 (Mercer, 1989).

Even as dramatic as the suicide statistics are for elderly persons, they probably represent a gross underestimate of the true magnitude of the problem. The reasons for this are two-fold. First, even when suicide is suspected, it is often not listed as the actual cause of death on most death certificates. Because the elderly often have multiple chronic conditions, are taking multiple medications or treatments which could explain their death, and are chronologically closer to death, there is a greater possibility that death will be attributed to frailty and advanced age. Second, suicide rates do not take into consideration indirect or passive suicide (e.g., refusing to eat or drink, stopping medications or treatments, alcohol abuse), which is a substantial problem, particularly among institutionalized elderly. Thus, suicide among older adults may be an even larger problem than what is currently believed. And of great concern is the fact that suicide is expected to double in the over 65 year old age group in the next 40 years (Whanger, 1989).

Unlike younger age groups, suicide among elderly individuals is seldom a mere cry for help or an attention getting mechanism (Miller, 1979). In fact, an elder's failure to complete the suicide is more often the result of bungling the attempt rather than ambivalence about whether to live or die (Busse & Pfeiffer, 1969). The ratio of attempts to completions is about 20:1 for persons age 40 and younger and only 4:1 for persons over the age of 60 years (Blazer, 1988). The attempt to completion ratio is much lower in the elderly for two reasons: older adults tend to use more violent and lethal means (e.g., gunshot to the head) and they communicate their suicidal intentions less frequently than do other age groups (Osgood, 1985). In sum, suicide must be considered a serious problem for elderly who are five times more likely to kill themselves than a younger person.

A number of clear-cut risk factors in elderly suicide have been identified, including unemployment, isolation, poor health, pain, depression, alcoholism, low self-esteem, feeling rejected, a history of mental illness, and previous suicide attempts (Osgood, 1985). Depression is believed to play an important role in suicide among older adults, causing profound feelings of hopelessness and despair, inadequacy, uselessness, demoralization, marked insomnia, imaginary physical symptoms or hypochondrias (Osgood, 1985; Mellick et al., 1992; Blazer, 1989). These feelings often compound real life stressors such as illness, pain, and isolation and reinforce the belief that life is not worth living and that things will not improve.

Although no prevalence rates are available for the rural elderly, suicide is a substantial problem among elderly as a group and therefore, we surmise, for rural elders as well. Rural elderly are more likely to be geographically isolated, to lack access to health and social services which may alleviate the real life stressors that are associated with suicide, and are unlikely to be identified or treated for the underlying depression that puts them at risk. In addition, the rugged individualism that characterizes many rural elderly often stands in the way of seeking out assistance and increases fear of institutionalization, factors that further reduce the risk that the depressed or suicidal elder will be identified and assisted.

Alcoholism

Contrary to popular belief, the elderly are as much at risk for alcoholism as any other age group. Alcoholism affects about 10-15% of older adults, the same rate found in the general population (Ostrander, 1992). Estimates indicate that there are approximately three million elderly alcoholics in the United States, although conservative estimates suggest that only 15% receive alcoholism treatment services (Edwards, 1985). Substance use and abuse in this group has been frequently overlooked both in gerontological and alcohol research. Until recently, the elderly substance abuser has been viewed as little more than an innocuous societal element and, as such, has been neither the subject of an appreciable investigatory interest nor the beneficiary of effective intervention (Pascarelli, 1979).

In recent years, there has been a renewed interest in aged alcohol/substance abusers, their patterns of abuse, and the development of treatment methods and programs that are meaningful and effective with this age group. Epidemiological studies have confirmed that alcohol is the substance most likely to be abused among elderly (Edwards, 1985; Miller, 1985; Pepper & Stover, 1979; Simon, 1980) and that the risk factors for alcohol abuse among elderly are the similar to those for the general population: male sex, poor education, low income, and a history of other psychiatric disorders, especially depression (Blazer, 1989). However, longitudinal studies of risk factors for alcohol problems in the elderly are virtually nonexistent.

Other studies not only support the belief that alcohol abuse among the elderly is a problem but also suggest that the problem is frequently under-reported (Mishara & Katenbaum, 1980; Williams, 1984). The discovery that an aging parent is abusing alcohol may be denied by middle-aged children or grandchildren because the thought offends their social sensibilities (Maddox and Blazer, 1985). And in some cases, the elder's alcohol consumption may be actually be supported or facilitated by the family system, behavior that is consistent with the belief that drinking is one of the "few pleasures left in life" and that it's "not hurting anyone," a phenomenon commonly encountered by clinicians of the Mental Health of the Rural Elderly Outreach Project (Krach, 1987).

Increased interest in alcoholism among elderly may be the result of a perception that late life is a time of stressful events that may precipitate alcohol consumption (Blazer, 1989). However, there is a paucity of research and literature dealing specifically with the rural elderly. Alcohol use, a common and culturally acceptable strategy for reducing stress, may increase as the older person encounters late life stressors such as retirement, loss of loved ones, increasing physical disability, and social isolation. In fact, as many as one third of elderly who abuse alcohol develop their dependence in later life while the remaining two thirds have chronic abuse problems. Several factors have been associated with late-life alcoholism including habitual drinking prior to late life, personality factors, and environmental factors (Glatt, 1978). Personality characteristics that seem to predispose to alcohol abuse in later life include anxiety and worry about one's social environment (Blazer, 1989). Thus, losses that tend to cluster in later life (e.g., bereavement, widowhood, relocation, changes in lifestyle) may contribute alcohol abuse among the aged. These problems may be further complicated by societal attitudes, boredom, lowered self-esteem, and the loneliness that accompanies increasing social isolation (Buckwalter & Clement, 1992). Moreover, the problems of dual diagnosis (depression and alcohol) among the rural elderly may be larger than previously thought (Krach, 1987; Russell & Buckwalter, 1989) and deserves increasing attention from both clinicians and researchers.

Dementia

Alzheimer's disease (AD) is a chronic, common, costly and increasing health problem, affecting 10% of persons between the ages of 65-75, and 25% of those over age 85, or more than 4 million Americans (Evans et al., 1989). There is no data available on the prevalence of dementia in non metropolitan areas to suggest that place of residence influences distribution of the disorder. The course of AD, while inexorably deteriorating, is unpredictable, lasting an average of 10 years. Early clinical manifestations include memory impairment, sensory changes, losses in judgment and logic as well as subtle personality withdrawal. These are followed by greater deficits in memory, and progressive decline in self-care ability, leading to greater dependence on caregivers for assistance with functional needs. As the percentage of elderly Americans increases (from 11.3 % in 1980 to 21.6% by the year 2040), the number of cases of dementia is expected to quintuple (OTA, 1987). Somewhere between one-half to two thirds of dementia patients live at home (Rabins, 1984) and this trend is expected to continue with projected cutbacks in services such as respite care for this population. Due to the chronic, debilitating nature of this disease, it is estimated that at least 15 million additional family members are also affected (Cohen & Eisdorfer, 1986). Although the financial impact of AD in rural areas has not been analyzed, total costs to society exceed $88 billion annually. These monetary estimates in no way reflect the human costs of this devastating disease which represents an escalating health care problem that currently cannot be prevented nor its course reversed (Advisory Panel on Alzheimer's Disease, 1989).

In rural settings, specialized diagnostic and evaluation services for dementia are extremely limited, and service providers in rural settings are reporting increased difficulty in locating both professional and nonprofessional help to provide hands-on care for community dwelling elderly with AD. Additionally, nursing homes are closing beds or restricting admissions due to a shortage of nursing assistants to care for the cognitively impaired (Governor's Task Force on Alzheimer's Disease and Related Disorders, 1989).

Available, affordable, accessible, and understandable mental health services are needed to address depression, dementia, substance abuse and other mental health problems of the rural elderly. Strategies are needed to demystify the mental health process and to provide a better definition of mental health needs in this population. Social services that provide attention to and assistance with the problems that underlie and precipitate the onset of mental and emotional difficulties in late life are also needed. Unfortunately, even when mental health and social support services are available to elderly, they are underutilized by this population. The major barriers to service utilization by the mentally ill rural elderly, which are critically important to understand as services are being developed for older adults, are discussed in a subsequent section of this paper. First, however, a historical perspective on mental health services is presented as a framework for understanding current issues and common impediments in the delivery of mental health services to elderly.

MENTAL HEALTH SERVICES: A BRIEF REVIEW

Historical Influences.

Treatment of the mentally ill in this country has evolved from an era of criminal confinement, through a period characterized by custodial care and management, to a more recent focus on intensive treatment and rapid rehabilitation. Deinstitutionalization in the 1950s, 60s and 70s was accompanied by inadequate discharge planning efforts and too few community mental health centers to meet the demands of outpatient treatment and follow-up. Nationally, fifty state hospitals closed, and many others consolidated (Dorwart, 1988). The rate of reduction of inpatient census changed from 1-2% from 1955-65 to around 5% annually between 1965 and 1975. Thus, fewer elderly with mental problems were residing in state hospitals or mental health institutions, resulting in an influx of mentally ill elderly into the community, general hospitals, and nursing homes (Goldman, 1984). Many former state psychiatric patients are now homeless, neglected or abused, in poor health and dependent upon the social service system for the necessities of life once provided by state hospitals (Bellack & Mueser, 1986; Cordes, 1984).

Geriatric patients are also more incapacitated and frail than ever before (Hanson, 1990). Of 4,000 newly admitted residents to nursing homes in 1985, over half were dependent in at least five activities of daily living (i.e. bathing, toileting, feeding, grooming, transferring). The influx of patients with Alzheimer's disease and other behavioral problems to long term care facilities prompted Liptzin (1986) to label nursing homes as the "psychiatric ghettos of the 1990s". Unfortunately, the quality of life for many chronically mentally ill older adults living both in the community and long term care facilities is severely compromised. It has even been argued that in some respects the mentally ill were better off before the deinstitutionalization movement (Gralnick, 1985).

Characteristics of the mental health system.

Ideally, the mental health system should promote the independence of older persons in making decisions and in performing everyday activities, and should encourage support services in the least restrictive environment, preferably at home or other community settings (White House Conference on Aging Report on Long-Term Care, 1981). "Aging in place", or the ability to remain in one's setting of choice, is influenced by emotional ties and financial considerations, and is also directly related to the availability and accessibility of resources and services to accommodate the increased dependency needs of the elderly (Koff, 1992). Services such as home health, homemaker, personal care and transportation are essential components to community based management of the mentally ill elderly that enable them to retain their residence and to function at an optimal level. However, the demands for these services imposes additional financial and resource burdens on Area Agencies on Aging (AAAs) -- agencies which have traditionally held the mental health needs of their clients as a low priority.

In the best of all possible worlds, the mental health system and aging network should share responsibility for making appropriate, cost-effective, accessible and humane care available to all older persons who need it, as well as supporting the care provided by family and friends. Data suggest that when mental health, aging services and other health and human services providers build linkages and cooperative service ventures and seek to develop and maintain a continuum of services that range from prevention to illness treatment, their elderly clients are better served (Lubowitz, Light, & Bailly, 1987). This continuum of services would provide community education to increase coping and adaptation among older adults and their families and improve the likelihood of personal planning that would prevent stress later in time. The continuum would provide social support services to reduce the impact of the stressors that cluster in late life and contribute to the onset of mental and emotional difficulties among the aged. The service continuum would facilitate early identification, help differentiate mental health from medical problems, and reduce the risk of premature institutionalization. And it would offer necessary support, supervision and assistance to chronically mentally ill elderly, allowing them to live in the community rather than in community-based institutions. In an ideal system, cooperation between agencies and funding sources would be the "norm," rather than the current state of "turf" battles and competition, freeing providers to focus on their attention on the changing needs of the population they serve. Regrettably, this ideal system is nonexistent in most rural settings.

For example, data from a survey of rural caregivers of persons with Alzheimer's disease (Russell, Hall & Buckwalter, in press) suggests that the mental health system has failed this growing, vulnerable population in some key ways. Caregivers reported that they were burdened by multigenerational responsibilities and competing demands from the workplace, unavailability of "Alzheimer's capable and friendly" services, and lack of knowledge of community resources. In fact, in many rural areas little or no respite for family caregivers is available (Breyspraak, Halpert, & Shaprt, 1986). Rural caregivers were also reluctant to pay for formal services even when they were available. Only 51% of the 107 caregivers surveyed stated that they used any community based services and cost was consistently reported as a major barrier to service utilization. Subjects spent anywhere from $16 to $850 monthly on services and supplies, and structural modifications for the home, and 67% of these costs were borne by the caregivers themselves. In light of these findings, policy makers should consider tax credits or direct subsidies to rural caregivers of the mentally ill and cognitively impaired elderly in an effort to ease their financial burdens and increase use of appropriate supportive services.

The elderly have traditionally underutilized mental health services. Only about 5% of patients at community mental health centers (CMHCs) and less than 2% of private psychiatric patients in rural areas are elderly (Weber, 1990). Data from the American Psychiatric Association suggest that total beds for both acute and long term psychiatric care, as well as for substance abuse treatment, comprise only about 14% of the beds in rural hospitals -- a percentage deemed inadequate for levels of psychiatric problems (Riffer, 1986). As noted previously, the comprehensive array of services needed to keep mentally ill older adults functioning in the community is often not available in rural areas.

In fact, in rural areas, jails are often used to contain mentally ill people and nursing homes have become, in a sense, the "custodial prisons" for the mentally ill rural elderly. Because rural areas have a high proportion of nursing home beds, and lack a comprehensive community-based long-term care system, many older residents are institutionalized. Here they are provided with physical care but go without active treatment for their emotional problems. In spite of federal mandates such as the Omnibus Reconcilation Act of 1987 which addresses the need to identify and treat mentally ill nursing home residents, appropriate and "active" intervention in this setting is close to nonexistent. In general, the range of health care services, including mental health services, for rural Americans is substantially more narrow than for their urban counterparts, with fewer alternatives and professional health care providers available (Coward & Cutler, 1989).

On the positive side, rural settings appear to offer more natural support systems, a strong sense of community and social support because of family and religious values and more lasting friendships, (Revicki & Mitchell, 1990), greater tolerance for deviant behavior (Jones & Parlour, 1985), and fewer bureaucratic barriers. Interestingly, despite comparatively adverse conditions and evidence of diminished health status, few differences in overall life satisfaction and morale have been documented between rural and urban elderly (Scheidt & Windley, 1983). Scheidt (1981) noted that self esteem and morale appear "linked to opportunities to establish warm, supportive relations, to see oneself valued as one who can contribute to the mainstream of the community" (p.78), and satisfaction with the environment has been linked to better mental health outcomes in the older adult population (Scheidt, 1985). The size and stability of the community may also facilitate follow-up services, and help to maintain chronically mentally ill patients in the community (Mermelstein & Sundet, 1989).

As noted previously, a number of factors are thought to adversely influence the appropriate utilization of mental health services by the rural elderly, including sociodemographic, economic, and cultural issues; the lack of mental health professionals trained to work with aged individuals; and the stigma surrounding mental illness and it's treatment. Each of these is discussed briefly below.

BARRIERS TO MENTAL HEALTH CARE

Sociodemographic, Economic and Cultural Issues

A number of socioeconomic, economic and cultural issues interfere with the utilization of mental health services by elderly individuals. This section emphasizes rural/urban differences in terms of service use, diversity of need, values and beliefs, and access to health, mental health and social services. Cultural beliefs and gender differences are also discussed.

The literature suggests that the mental health needs of the rural elderly are not significantly different from those of their urban counterparts (Mueller, 1981), but that service delivery strategies need to be (Ginsberg, 1992; Nofz, 1986). Bachrach (1981) has classified rural and urban differences in human service delivery according to five factors: 1) non-social; 2) demographic and ecological; 3) socioeconomic; 4) interpersonal; and 5) ideological. These factors suggest that the geography, tax and resource base, power structure, and value systems of rural areas differ from urban regions, and affect the delivery of mental health services. For example, distance must be considered in terms of travel time to services; a sparse population limits the tax base; poor counties have more difficulty financing mental health services; the rural power structure (which is often concentrated in a few people or organizations) may determine which programs are allowed to operate; and conservative ideologies may foster stigma and self-blame (Palmer & Cunningham, 1982), especially among the elderly.

Diversity Within Rural Elders. The rural elderly are not a homogeneous group that enjoys a common culture. Rather, like other rural residents, they are geographically, socioeconomically, occupationally and ethnically diverse. There is a lack of research, and thus an inadequate knowledge base about the mental health needs of minority elders in particular. However, despite this heterogeneity, some commonalties have been noted. For example, the rural American population is more impoverished with higher unemployment rates, less educated, and older than urban dwellers (Cordes, 1989; DeLeon, 1989). This age difference may be important with regard to the increased need for health-related services among older adults (Dwyer, Lee & Coward, 1990), and the increasing incidence of cognitive disorders such as Alzheimer's disease. Further, elderly in nonmetropolitan counties have more chronic illnesses, more limitations in activities of daily living, and lower overall health status (Kim, 1987; U.S. Office of Technology Assessment, 1990).

Rural Values. Several values and themes seem to predominate in rural settings. These include: subjugation to nature, individualism, an emphasis on primary relationships and family ties, traditionalism, fatalism, the Protestant work ethic, conservative beliefs, and strong religious values. Youmans (1977) identified three value systems that impact upon mental health services in rural areas: 1) identification with the community and a sense of belonging; 2) a work or "doing" orientation; and 3) a fatalistic attitude. These beliefs may explain, in part, why decreased ability to perform activities of daily living is correlated with decreased morale among rural elderly, and why supportive social services and health care programs may be viewed with suspicion and contempt (Harbert & Wilkinson, 1979).

Support for this contention is also derived from qualitative analysis of presenting complaints from over 800 clients referred to the Mental Health of the Rural Elderly Outreach Project (Buckwalter, Smith, Zevenbergen, & Russell, 1991). These data suggest that many rural elderly still believe that they should be able to handle all their problems themselves, and view mental health assistance as a sign of personal weakness, or even defeat (Smith & Buckwalter, in press). In sum, values and attitudes may influence the labeling of behavior as pathological, prevent older adults in rural areas from getting needed mental health assistance, and affect the type of treatment sought. Much of the research related to rural value systems is old. More up to date studies are warranted to document current values and their relation to effective service provision.

Access to Services. Many rural hospitals and health centers, where the elderly traditionally receive mental health care, are facing a financial crisis and some will be forced to close, resulting in fewer providers and more distance to access services (Beaulieu, 1992). Geographically inaccessible services are a particular problem for the elderly, many of whom no longer drive. In nonmetropolitan counties, transportation services for the elderly are severely restricted outside of the county seat. Research by Patton (1989) indicated that the economic status of the rural population has deteriorated; hospitals are in danger of extinction; access for health care has underscored the continuing shortage of rural health care facilities; and there is disparity between Medicare reimbursement to physicians and health clinics in rural communities as compared to urban communities. These data are particularly troubling in light of the higher incidence of chronic illness and lower overall health status of the rural elderly, suggesting a greater need for long term care services in this population (Beaulieu, 1992).

The situation for mental health-related facilities is equally bleak. Only 7% of rural counties have a general hospital with psychiatric facilities vs. 33% for urban areas (Flax et al., 1979). Rural CMHCs are more likely to be located in the South, and are more likely than urban CMHCs to serve an economically disadvantaged population (Wagenfeld, 1990). Rural residents have less access to psychiatrists and must therefore rely more on general practitioners who are often reluctant and/or ill-prepared to accurately diagnose and treat geriatric psychiatric illness (German et al., 1987; Gurland & Cross, 1982; Linn et al., Waxman & Carner, 1984). As a result, polypharmacy as both a cause and result of mental and emotional disorders is an important and often overlooked treatment issue (Birkett, 1991; Douglas & Rush, 1988; Feinberg, 1989; Zaske & Hunter, 1986). In many cases, nurses and social service workers, naturally occurring community supports, and indigenous helpers provide the bulk of mental health care in rural settings (Jones & Parlour, 1985). Even when psychiatric social workers and nurses are available to assess and treat rural elders, the lack of diagnostic, medication, and consultation services by psychiatrists obstructs third party reimbursement and interferes with comprehensive care, creating yet another set of problems to overcome.

Mental health services in rural states are often structured on a regional basis. Often a variety of services are clustered in larger cities and satellite offices, when they are available in the more rural regions, are often minimally and sporadically staffed. Longer distances to services, compounded by bad weather, lack of public transportation and inadequate road conditions (Coward & Cutler, 1989), also increases coordination and communication difficulties, particularly for the elderly. Even when special transportation services such a senior buses are available, many elderly resist, complaining that they are both physically and emotionally uncomfortable.

Cultural Beliefs. Because cultural values are determinants of health perceptions and behaviors (Bushy, 1991), mental health workers must also understand the value of, and be able to explore the value orientations, stressors, coping strategies and goals of their older clients in order to provide effective treatment (Delworth et al., 1987; Dietz, 1991). As noted before, the rural elderly are not a homogeneous group (Harbert & Ginsberg, 1990). Ethnic and cultural differences are prevalent even in the predominantly white farmlands. Individual communities may be characterized by traditional values of the "old country," whether German, Greek, Irish, or Scandinavian in origin. The farm belt, like other states across the country, also has as a modest but substantial cohort of Hispanic origin elderly which is increasing in numbers. In fact, current trends and projections suggest that cultural and ethnic diversity will become increasingly prevalent in the next century (U.S. Bureau of the Census, 1992).

Moreover, mental health providers, especially in the rural south, must recognize and strive to understand folk healers in order to better address the health and mental health needs of older African Americans and to open up communication channels (See, 1991). These indigenous healers can take many forms, including spiritual counselors, herbalists and "root" doctors, and shamans. Their "remedies" for various emotional afflictions vary according to cultural and social customs and geographical region, and their definitions, diagnoses, interpretations of symptoms, and treatments may differ dramatically from traditional psychiatric practice. In many rural areas "mental problems" are considered the domain of the family or the church, and those who rely on scientific medicine are viewed as desperate (Hill, 1985). The important role folk healers, and folk beliefs and practices play should not be overlooked or mocked by more traditional health care professionals (See, 1991). Differences in values and beliefs must be considered in all service and research efforts in rural settings (Bastida, 1988).

Gender Differences: Older Rural Women. A majority of the older population (67%) are women, many of whom have special needs. As Fahey (1988) has noted, women live longer than men, spend more time alone, and are generally more vulnerable to the problems of aging in rural settings. Older women tend to have more chronic illnesses and are more likely to have lower incomes than men (Szinovacz, 1982). They report more general health problems, higher levels of depression, and lower self-esteem (Gore & Mangione, 1983), and are more likely to be widowed, live alone, and be impoverished (U.S. Bureau of the Census, 1992). These problems may be exacerbated in older rural women who are less likely to be aware of and have access to services to assist them with their health and mental health problems (Krout, 1988), although more research, especially of a qualitative nature, is needed to validate this assumption.

A recent study by Gale (1992) found that among rural older women there was very low use of either inpatient or outpatient mental health services (2% of the sample), although 11% of the sample had used psychotropic drugs in the past 6 months, 9% were currently using them, and another 11% felt the need for psychotropic medication. A comparison with older urban women showed that urban dwellers reported higher levels of stress and greater use of health care services, and that rural women reported better psychosocial health. Although stress research related to health among elderly women is limited, acute stress does not appear to be a significant etiology for mental illness among older women in rural areas. Norris and Murrell (1987) reported that the elderly in rural areas have no adverse effects from limited episodes of stress, and others (Bigbee, 1990) have found no significant differences in stress levels between urban and rural women. As noted above, more research is needed to validate these findings and to examine the interaction of gender and age (especially studies of chronic and persistent stressors), the role of stressors, and adapting to dependencies in later life in the development of emotional problems in older rural women.

Lack of Trained Mental Health Professionals in Rural Settings

Another major area of concern in providing mental health services to rural elderly is the lack of trained mental health professionals. The rural community is not rich with professional human service options, and the role of the mental health worker in rural areas is a demanding one. Community Mental Health Centers (CMHCs) located in small towns and rural communities experience more problems with human resources, recruitment and retention, and the scarcity of highly trained professionals than do urban agencies (Stuve, Beeson & Hartig, 1988).

The manpower shortage in mental health care providers affects both the availability of services and the quality of care provided to the rural elderly. Many rural CMHCs do not provide any type of specialized service to elderly, and only marginally serve elders via traditional outpatient services (Weber, 1990). The scarcity of human resources in rural settings often demands that an emphasis be placed on "rehabilitative potential," which classically focuses on therapy for children and adolescents, and crisis intervention and brief therapies for adults. Preventive services, including community education and consultation services that are critically important to reducing the stigma surrounding mental illness, improving early recognition and treatment, and reducing the risk of institutionalization and long-term disability, typically take a "back seat" to outpatient services that generate income when resources are limited (Zevenbergen & Buckwalter, 1991). Needless to say, attention to the unique needs of elderly individuals suffers in such a climate: direct services are often limited, education of other health and social service providers regarding mental illness in later life is limited or nonexistent, and cooperation and linkages between agencies is poor. In short, the lack of mental health professionals who are sensitive to, knowledgeable about, and capable of managing geriatric psychiatric problems and complex legal and ethical issues such as determination of competency, and the balance between safety and autonomy for demented clients perpetuates the problems experienced by rural elderly.

Gerontological education and training for health care professionals, like research, has centered on urban concepts and practice settings. In general, there is a deficiency in the number of courses available on both rural health care issues and geriatrics, contributing to ill-prepared practitioners and to service delivery problems in rural America. As noted before, the lack of trained professionals contributes to the problem of providing appropriate mental health services to the rural elderly in several ways. First, some providers discriminate against older clients and view the elderly as "boring" and "unable to change" -- the proverbial "you can't teach an old dog new tricks." They are unmotivated to work with older individuals, whom they regard as "hopeless cases" (Buckwalter & Smith, in press). Other health care professionals lack the skills and training necessary to work effectively with the elderly. Educational programs that prepare mental health professionals in a variety of disciplines (e.g. medicine, social work, nursing, psychology) fail to adequately address late life developmental tasks or problems associated with advanced age, cultural beliefs and values, or therapies that are particularly useful for older adults. And in the absence of skilled geriatric psychiatric clinician to take leadership positions in the development of service, many rural CMHCs continue to focus their care on younger age groups.

Although the "generalist" perspective, from which clients are viewed within the context of their total environment (Dunbar, 1982), is essential to meeting the diverse needs of elderly clients in rural areas, it may be a disadvantage in terms of providing specialized geriatric mental health treatment and astute medication management. In some cases, cost factors and the multiple demands on mental health workers of the rural agency may actually work against the provision of state-of-the-art, specialized psychiatric services for individual elderly clients. Solutions that have been proposed include resource sharing to fund a multi-agency geriatric mental health specialist (Intermill & Rathbone-McCuan, 1991), cooperative agreements between rural communities and nearby urban centers to enhance service provision (Rosenblatt & Moscovice, 1982), and linkages with lay, nontraditional service providers. Other potential solutions to professional staffing needs in rural areas are highlighted below.

In general, rural health care issues must be recognized more in the education of health care professionals, including changes both curricula and practicum sites that emphasize rural, gerontological, and geriatric mental health issues. More continuing education and workshops need to be provided on rural health issues, and cooperative interdisciplinary relationships should be modeled by educators (DeWeaver, 1990). Specifically, there is a need to develop formalized geriatric mental health training and education programs (e.g., on rural health, mental health/illness identification and treatment, legal and ethical issues, etc.) to address the wide array of professionals and paraprofessionals already working in the field of aging, as well as to provide continuing education to those in the field. In most states, existing geriatric education resources are uneven in quality, disperse in location, diffuse in focus, variable by discipline and often lack a coordinated mission. Given the unique problems encountered by the rural mental health professional, Sedgwick (1977) has argued for curriculum and practice site changes (to the rural community) which includes knowledge of and sensitivity to the rural non-urban people as well as research into their unique health patterns and disease processes. When the University of Northern Colorado extended undergraduate nursing practicum projects into rural areas, 1/3 of the students who participated in the program took positions in a rural settings after graduation, compared to only 4% of those who did not have a rural placement (Arlton, 1984).

A number of training models have been proposed or are under study. Kim (1981) set forth an "integral and convergent educational model" with a specialized rural gerontology curriculum in an effort to improve rural health care. Wilson (1981) described an innovative demonstration and training project in Kentucky designed to "recruit, train and develop manpower services" that address the mental health needs of rural residents. More recently, training projects have used innovative telecommunications systems to reach practitioners and consumers in rural settings (Pickard, 1990).

Twenty-one nursing schools are now teaching courses to learners in rural areas through telecommunications programs (AACN Issue Bulletin, 1989). Another innovative example is the "Geriatric Mental Health Training in Rural Long Term Care Settings" project, currently funded by the Division of Nursing, that broadcasts one-hour training modules to nursing staff in rural long term care facilities, using the two way interactive satellite television capabilities of the community college network to reach practitioners who might not otherwise drive long distances to attend continuing education programs. Programs of this nature are thus capable of increasing access to geriatric mental health education to health care professionals who reside in small or remote locations. Other rural outreach educational programs are linking academic settings with the underutilized resources of cooperative extension services (CES) to train mental health professionals in rural settings. As Halpert and Sharp (1991) note, CES professionals can provide the "structural and program delivery capacity to help shape health care delivery in rural areas through community organization and education" (p.23).

Educational efforts such as those cited above heighten awareness of the special mental health promotion and treatment needs of older rural residents, and may foster a commitment to serve this neglected population. Further, because the rural elderly in particular have limited access to psychiatrists and are underserved by CMHCs, general practitioners, public health nurses, social service workers, psychologists and other core disciplines must be able to understand the mental health needs of this population, provide basic care, and make referrals for needed services.

Federally funded Geriatric Education Centers (GECs) can play a pivotal role by incorporating mental health and service delivery content into their seminars, site-visits, workshop and fellowship curricula (Buckwalter, McLeran, Mitchell, & Andrews, 1988). GECs in various states are diffusing the substantial and growing geriatric mental health knowledge base to currently underserved medical, nursing, dental and social work faculty, and to practitioners in rural areas. A number of interdisciplinary training formats have been effective, including summer institutes and week-long intensive training sessions that allow exposure to geriatric mental health knowledge, teaching and research methods, as well as the development of new or intensified interest areas by geriatric scholars and clinicians. Thus, geriatric mental health education programs are conceptualized as an important link between the emerging research knowledge base in the field and intervention programs. GECs can serve as a useful medium for the translation of scientific knowledge into programs and interventions for the mentally ill rural elderly. Additionally, the federal government supports the training and placement of health care providers such as geriatric nurse practitioners in rural areas through special advanced education grants from the Bureau of Health Professions. The Area Health Education Centers Programs (AHEC) also supports a number of projects that train, provide continuing education, or facilitate placements and preceptorships in rural settings (Nichols & Geller, 1990).

On balance, rural health care professionals earn less than their urban counterparts (Ambrosius, 1982; Kim, 1982b). Thus, another important strategy to address manpower shortages is to develop financial recruitment and retention incentives to attract mental health professionals to designated shortage areas and to work with underserved populations such as the rural elderly. Other potential solutions include the creation of new types of mental health professionals, new regulations, and occupational licensure laws on rural manpower shortages. What is unknown is whether the job tasks and scopes of mental health care professionals currently practicing in rural areas could be expanded or "re-engineered" to provide more help for the rural elderly.

To address this issue more research is needed. Information regarding areas of concern and priorities for enhancing the quality of geriatric mental health services need to be collected from providers. Data also needs to be analyzed from a variety of rural regions nationally including existing regulatory and state occupational licensure policies and requirements which may inadvertently and unnecessarily contribute to rural mental health manpower shortages. This type of research could identify specific job tasks/patient services which could be provided by members of more than one occupational group if existing licensure policies and requirements were changed.

Barriers to Care: Stigma

As mentioned earlier, an important and neglected role for mental health professionals practicing in rural settings is to provide more education about mental illness to combat the stigma and myths that surround mental disorders. Mental illness has long been associated with criminal behavior, evil forces, incapacity, and confinement in institutions, both prisons and mental hospitals. Unlike physical illness, mental illness is often viewed as a sign of personal weakness rather than as an illness that is beyond the person's control. In combination, these factors contribute to the underutilization of mental health services by elderly, and particularly this cohort of elderly who associated mental illness with permanent institutionalization.

Although there is some evidence that resistance to use of mental health services in rural areas is diminishing, Rathbone-McCuan and Hashimi (1982) note that, "The fear of stigma is so strong among some of the elderly that they never reach out for assistance" (pg. 102). Service refusal data from the Mental Health of the Rural Elderly Outreach Project (Buckwalter, et al., 1991) confirm that stigma is still a prevalent barrier to seeking or accepting mental health assistance for the 13.1% of 806 elderly clients who refused treatment. Content analysis of their reasons for service refusal suggests that many elders fear being labeled as "crazy" and their families are afraid that neighbors and friends will find out about their older relative's mental problem and that they will become the topic of town gossip, the brunt of bad jokes, and will be avoided, shunned, or ostracized.

For example, for some older individuals, the word "schizophrenia" still evokes images of "Jekyl and Hyde" and any type of delusional experience is seen as evidence of being permanently insane (Smith, 1990; Smith & Buckwalter, in press). The idea that most mental illness is quite treatable and reversible is unknown in some rural communities. "Depression" is mocked as an everyday occurrence that the older person should be able to handle on his/her own. And the words "senile" and "demented" strike a note of fear in the hearts and minds of many rural folks, especially the elderly. In some cases, Alzheimer's disease has elicited the same type of paranoid reaction that was once seen with a diagnosis of cancer, and is now observed with AIDS -- lack of understanding, fearing the strange behaviors, and the belief that the disorder is "catching" (Smith & Buckwalter, in press; Buckwalter & Smith, in press).

Moreover, although psychotropic medication has virtually eliminated long-term institutionalization as a form of treatment for mental illness, some rural elderly continue to believe that they will be abandoned or "locked" up" if they accept any type of assistance for a mental problem. Many elderly are under the impression that mental illness is treated by putting people in state mental hospitals or asylums, as was done for most of their lives, and they fear that outcome for themselves. To the older person who values open spaces and independence, institutionalization may loom as a "fate worse than death." However, more research is warranted to validate these perceptions.

Thus, mental health service providers in rural areas are challenged to confront the barrier of stigma associated with mental illness by providing public education that is aimed at demystifying mental illness. Community education about what mental illness is and is not, prevalence rates, current theories on causation, treatments, and rehabilitative potential are critically important to reducing fear, increasing referrals, and improving the scope of services provided. Likewise, mental health professionals are challenged to make their services "user-friendly:" understandable, acceptable, and geographically, physically, psychologically, and longitudinally accessible (Bachrach, 1986).

Although utilization of mental health and other formal services by the elderly has been shown to be helpful, little research has been done in relation to barriers to care in community mental health centers (Speer, Williams, West & Dupree, 1991), and even less on mental health centers in rural areas. Factors that require further investigation with regard to service utilization by the mentally ill rural elderly include issues related to ability to pay and feelings of stigma; for example, the influence of fee schedules, problems that are deemed "acceptable" reasons for which to seek counseling, acceptable sites for services, and acceptable names of mental health agencies (Speer et al, 1991).

INFORMAL CAREGIVER NETWORKS, SOCIAL SUPPORT AND MENTAL HEALTH

For innovations to be effective, mental health workers must take a genuine interest in enhancing the strengths of the rural community (Murray & Keller,1986), and build upon the strengths of the informal helping network. However, mental health professionals and informal caregiving networks (e.g. family, neighborhood networks) often have different priorities, characteristics, and assumptions when it comes to the use of mental health services (Froland, 1980). Ideally, the two caregiving systems should not substitute, but rather complement each other and work as partners (Litwak, 1985). More often, however, mental health providers in rural areas are turned to only after family resources have been exhausted (Cantor, 1980).

Although the mental health needs of the rural elderly cannot be met by informal social support networks alone (Rathbone-McCuan, 1992), research suggests that the role of the family is an important and cost-effective one in the identification and management of emotional symptoms, and service utilization (Dwyer, Lee & Coward, 1990). Stoller & Forster (1992) identified that the rural elderly tend to manage their symptoms by themselves, and when they do discuss their symptoms with others, it is most commonly a family member or friend rather than a health care professional. Similarly, in a study of support resources endorsed by older rural women, Stockman & Delworth (1989) found that respondents were not interested in resources outside family and friends because they were concerned with issues of confidentiality. Respondents also felt that accepting services from agencies was "too close to charity" and that "people should be self-sufficient." Given these attitudes, it is troubling that many practitioners in rural areas are either unaware of informal systems or fail to use them to their advantage (Lauffer, 1978).

It has been suggested, although there is little research in this area, that older persons residing in rural areas are at particular risk for social isolation and minimal social network involvement because of a variety of factors, including poor health, financial limitations, transportation difficulties and loss of family members and friends. Failure to appreciate the important role of informal social support networks is unfortunate in light of social and economic changes in rural America during the 1980s that created conditions of chronic disadvantage that continue to exacerbate mental health problems among both young and old rural residents today. As younger family members have outmigrated from rural areas, the social support networks of many elderly have become smaller and less available (Coward & Lee, 1985; Stone, 1991).

The absence of social support has been shown to make the elderly more vulnerable to interpersonal and environmental assaults (Russell, 1986), and other adversities such as depression (O'Hara, Kohout, & Wallace, 1985). Cobb (1976) has postulated the "buffering" effects of social support, as a moderator of life stress, and the buffering hypothesis deserves more investigation among the rural elderly. Often the knowledge that help will be available if needed gives older adults the confidence to cope more successfully. Social supports are important not only for the instrumental assistance they provide, but also for the reinforcement and self-affirmation that comes from the empathetic interests of others. One area that has been significantly impacted by diminished social support networks is caregiving for frail and demented rural elderly.

Research by Dwyer & Miller (1990) examining caregiver stress and burden suggests that caregiving network characteristics, which substantially influence the quality of care provided to frail elders, differ according to place of residence. Both formal and informal services that may benefit elders and their caregivers are less likely to be available in rural areas (Coward & Lee, 1985). Thus, providing care for increasingly dependent older relatives can be especially difficult for rural caregivers who may be subjected to unique stressors (Marotz-Baden & Colvin, 1986) and whose own mental and physical health may suffer in response to the burdens of caregiving. A statewide study of 107 rural caregivers of persons with Alzheimer's disease (Russell, Hall & Buckwalter, in press) found that although caregivers reported a deep sense of personal satisfaction and growth, they also reported higher levels of depression and chronic health problems (e.g. hypertension, arthritis), and lower life satisfaction than non-caregivers in the same age group. Importantly, the amount of social support received from family and friends made the caregiving experience more bearable, and easier to handle for these subjects. Similar research comparing metropolitan and nonmetropolitan caregivers of cognitively impaired elderly (Russell, 1991) found that nonmetropolitan caregivers were less likely to receive a comprehensive diagnostic evaluation, more often received informal assistance in the caregiving process from their well spouse for such tasks as household chores, meal preparation, running errands, and supervision, transportation of their impaired family members. They also used less formal assistance such as in-home help, adult daycare services, social workers, support groups and medical services than their metropolitan counterparts.

Investigations of strain, social support and mental health in rural elderly individuals (Revicki & Mitchell, 1990) supports the work of Arling (1987) and others which found that demographic characteristics had little effect on mental health, whereas physical health status was highly predictive of life satisfaction and psychological distress. Disability associated with chronic illness and impairments in activities of daily living were related to increased psychosomatic and emotional distress in this population. Interestingly, social contacts and instrumental support had only modest a effect on life satisfaction, and levels of distress, and affective support was found to moderate the effects of strain (health-related) on mental health. More longitudinal research is needed on the interrelationships among stress, social support and mental health status of the rural elderly.

Thus, it appears that greater efforts are needed to link rural elders and their caregivers with programs designed specifically to meet their needs, keeping in mind that the use of formal services varies according to a variety of sociodemographic factors, and the close proximity of children. Consultative and educational strategies are also needed to empower the informal caregiving networks of mental health clients (Naparstek, Biegel & Spiro, 1982). Mental health professionals practicing in rural areas should facilitate and complement the efforts of informal social support networks, as the role of the family appears central to the prevention and treatment of mental illness and emotional distress (Miller, 1985).

OVERVIEW OF MODELS AND CHARACTERISTICS OF SUCCESSFUL SERVICES

> As we look to the future for older adults in these United States, two factors stand out -- the growing numbers of older citizens in need of a range of health and social services and the inadequacy and fragmentation of our present system for delivering such services. What must be developed is a continuum of adequate, available, acceptable services for all older adults, appropriate to their needs at any given time (Winston, 1978).

The two factors that Winston projected in his 1978 quotation have become a reality, but the continuum of services needed to meet the health and mental health needs of older adults is still sorely lacking in many rural areas. In a decade review of the health status, health services utilization, and support networks of the rural elderly, Dwyer, Lee and Coward (1990) noted that "the rural elderly are relatively disadvantaged in terms of both health status and access to health care services, and have little if any advantage over the urban elderly in their access to informal sources of care" (p. 379). To be successful, rural mental health services must mesh with other services and informal health networks. Service providers and researchers must understand and be sensitive to the rural value system and social ecology of the area. Otherwise, mental health workers may find themselves addressing assumed rather than real needs. Because of the nature of rural culture, borrowing successful urban techniques and imposing them without modification in a rural setting may not always be appropriate nor effective.

Effective mental health service delivery in rural America requires innovative approaches, coordination and cooperation among mental health and human service providers. Reciprocal exchanges and good communication have been identified as key elements in good inter-agency relations (Morris & Kirkpatrick, 1987). A more appropriate rural mental health delivery system must maximize limited resources, address unique community needs, provide continuity of care, and use professional, paraprofessional and lay personnel appropriately (Palmer & Cunningham, 1983). Clearly, more attention needs to be given to designing prevention services and the roles of paraprofessionals in prevention, education, service coordination, and help-building in informal networks (Jones & Parlour, 1985).

Comprehensive services require that mental health services be longitudinal, individualized, cover an array of modalities, be flexible, provide for an ongoing relationship between the older patient and service providers, be accessible physically, financially, psychologically, and maintain open communication within the service system (Palmer & Cunningham, 1982).

Most effective planning efforts begin with a needs assessment process that determines which services should be provided to the elderly, and who is eligible (based on income, age criteria, etc.) for the services (Intermill & Rathbone-McCuan, 1991). The needs assessment should determine the nature and magnitude of the problem, describe elderly consumer attitudes toward existing services, and then offer potential solutions. The needs assessment should also help rural planners and providers to determine which of a number of service structures would be most effective in a particular community.

At present, mental health services in rural areas are often fragmented because of funding and authority patterns. Nor are local, state and national mental health services delivered systematically (Manderscheid, 1984). The concept of human services integration (coordination), or an integrated service structure (combining elements of both direct and indirect service models) has been proposed as the best way to meet these challenges (Bachrach, 1981; Daniels, 1967). Integration can take many forms, including joint decision-making and policy making, co-location and shared services. The integrated service system approach offers several advantages, including staffing flexibility, maximum use of resources, an emphasis on preventive mental health services, and decreased "turfdom" among providers (Palmer & Cunningham, 1983).

Direct mental health services have traditionally been provided by CMHCs and their satellite offices (Ozarin, 1979), although CMHCs in rural areas serve proportionately fewer elderly than centers in more urban areas. Numerous recent studies have consistently found that although a significant number of elderly have mental health problems, their treatment needs have not been adequately addressed (Lebowitz, Light, & Bailey, 1987; Raschko, 1985; Smyer & Pruchno, 1984; Spore & Atchley, 1990).

Rathbone-McCuan (1981) described three approaches for organizing integrated services for the mentally ill rural aged: 1) the primary mental health base; 2) the aging network base; and 3) the primary health care base. The first approach attempts to make services more responsive to the needs of the elderly by expanding coverage to include at-risk persons. The aging network base uses the resources of the Area Agencies on Aging (AAAs), whereas the primary health care approach utilizes primary and comprehensive health centers to deal with problems that have both physical and mental components. Rathbone-McCuan (1981) suggests these three "single system approaches have the greatest value for offering temporary and limited solutions to meeting health and mental health needs of the rural elderly" (p.272), although none of them is sufficient to address adequately the mental health concerns in rural America. Thus, the best approach would seem to be one of multiple, integrated systems and joint health/mental health planning (Rathbone-McCuan, 1981).

The link between mental health and medical delivery systems suggested by the primary health care base has numerous advantages in rural areas as the elderly, in particular, often have multiple and interrelated health problems. Co-morbidity data from the Mental Health of the Rural Elderly Outreach Project found that 37.04% of the chronically mentally ill elderly clients referred to the program with a primary mental illness diagnosis also had significant co-existing medical problems including, for example: cancer, brain tumor, Parkinson's disease, chronic obstructive pulmonary disease, hip fractures, stroke, congestive heart failure, peptic ulcer, and asthma (Buckwalter, 1991). Integrating medical and mental health services theoretically should serve to increase the detection and referral of rural residents with mental disorders, increase the preventive nature of services, and decrease the perceived stigma of utilizing a mental health clinic, thereby enhancing compliance with appointments (Frangos & Chase, 1976).

Whatever model is employed, in order to be successful the agencies involved must share fundamental goals and communication patterns. Too often, collaborative efforts are doomed by misperceptions of goals and poor working relationships among professionals. Lack of centralization, coordination of agency efforts and relationship skills can also subvert the development of community treatment networks and interfere with continuity of treatment (Allness & Field, 1983). Thus, there must be a commitment from state-level mental health, health and aging services agencies to jointly plan and support integrated geriatric mental health services in rural areas, as described next.

PROGRAMS FOR THE MENTALLY ILL RURAL ELDERLY

According to the 1980 census, a higher percentage of persons over age 65 reside in nonmetropolitan counties than in metropolitan counties (13.0% vs. 10.7%, respectively) (Cordes & Wright, 1985). The rural elderly are a dually disadvantaged population, first by being old and often frail or ill in a society that emphasizes youth and vigor, and second by being rural with its concomitants of less available and less accessible health and human services (Buckwalter, et al., in press). The mental health delivery system must be reconceptualized and reorganized in order to identify and attract those elderly persons in need of services. In 1989, only 5% of patients at CMHCs and less than 2% of patients of private psychiatrists were older adults who lived in rural areas (Rural Elderly Networker, 1990), despite evidence that a significant proportion (up to 25%) of the rural elderly may suffer from psychiatric problems (Rosen, Coppage, Troglin, & Rosen, 1981). Further, Scheidt and Windley (1982) found that only 1% of small-town elderly used mental health services, whereas between 12-23% were "at-risk" for mental disorders. In general, older former mental patients as well as non-institutionalized community elders have a need for community treatment that is not being adequately addressed (Scheidt, 1985).

Outreach programs have been suggested as one effective approach in delivering services to the elderly, because those most at risk do not present themselves to mental health and social services agencies (Toseland, Decker, & Bliesner, 1979). Multidisciplinary outreach teams consisting of a psychiatrist, nurse and social worker can overcome some of the limitations of rural mental health services by providing coordinated identification, assessment and treatment of the rural elderly in their own homes (Lazarus & Weinberg, 1982). Outreach can effectively provide diagnosis and treatment for homebound rural elderly who have physical limitations, major psychiatric illnesses, or who are socially isolated. The outreach approach has proved helpful in treating both urban and rural elderly patients who might not otherwise enter traditional mental health programs until a crisis necessitates hospitalization (Wasson et. al., 1982; Buckwalter, Smith, Zevenbergen, & Russell, 1991). In general evaluations of outreach efforts suggest that they provide rapid and effective mental health assessment and treatment and minimize disruption and premature institutionalization of elderly persons (Kahn & Tobin, 1981; Reifler, et al., 1982; Buckwalter et al., 1991). Two such successful outreach programs are highlighted in the following section.

Elderly Outreach Programs

The Iowa Model. Iowa's Elderly Outreach Program (EOP), begun in 1986 with demonstration services research money from the NIMH and Administration on Aging, was a collaborative effort between a CMHC and an AAA. The EOP was designed to identify older individuals in need of mental health care, to deliver needed services, and to initiate and coordinate referrals to appropriate medical and social service agencies (Buckwalter et al., 1991). Because the rural elderly did not present themselves at the mental health center requesting assistance, the outreach model utilized a wide variety of traditional (e.g. discharge planners in institutional settings) and nontraditional referral sources. The goal of the project was to develop a partnership between the CMHC and the community, cultivating relationships with people who work with the elderly or who come into contact with them as part of their everyday activities. Using an approach developed by Raschko (1985), the project trained more than 600 "gatekeepers," or people who live and work in the rural community and who can identify and link isolated elders with sources of needed assistance. Liaisons were also developed with all elderly service providers in the existing case management system (e.g. visiting nurses, home health aides, etc.) and on-site psychosocial screening at well-elderly clinics were conducted regularly. Following referral, clients received a comprehensive, in-

home assessment from the multidisciplinary EOP team (consisting of a geropsychiatric nurse, social worker and psychiatrist) during which medical, psychiatric, and social problems and needs were reviewed (Buckwalter, Abraham, Smith & Smullen, in press). Over the past 5 years more than 800 elderly have been referred to the EOP, which has also proven to be a cost effective model of care, with per patient per year costs estimated at approximately $622. The majority of clients suffer from depression, followed by dementia, adjustment disorders, and problems in living (see Buckwalter et al., 1991, for a detailed description of the EOP and its evaluation). Additional programmatic services, such as a geriatric assessment clinic, education and training programs, and consultation services have developed as an outgrowth of the EOP (Buckwalter et al., in press).

The Virginia Model. Using the Iowa experience as a stimulus for action, psychiatric nurses at the University of Virginia joined forces with physicians and community agencies to develop another successful Rural Elder Outreach Program (REOP). The REOP, begun in March of 1991 and supported by grant funds from the Kellogg Foundation, also integrates many agencies and professionals from multiple disciplines in an effort to provide a well-rounded approach to assessment, consultation, case management, and psychosocial support services to high-risk patients, their families and caregivers (Buckwalter et al., in press). A key aspect of the REOP is to strengthen the self-reliance of rural communities in caring for their elders and to heighten awareness of aging and mental health issues. Unlike the Iowa EOP model, in which professional expertise and resources are more centralized, the REOP features a multilayered structure of lay, nonprofessional and professional resources.

Sixty-three patients were served in the first year of the project, and the estimated direct cost per patient, per year is $1,015. Most referrals to the REOP involve patients presenting with mental health problems too complex for existing resources to manage, and that require expertise beyond that provided in community agencies. The majority of clients (59%) have a primary diagnosis with an organic base: 24% present with dementia, 10% with dementia and depression combined, and 25% with various physical illnesses precipitating a psychosocial crisis. Another 17% of those served to date have a primary diagnosis of depression. Thus, both the Iowa and Virginia outreach models are serving older clients who otherwise might not receive needed services or who would fall through the cracks of the traditional mental health system in a cost effective manner.

Rural Adult Day Care Programs.

Adult day care programs have grown steadily in this country over the past decade, but mostly in major metropolitan areas. These programs provide a structured program of coordinated social, health and mental health related services in a protective group setting, for some portion of the day. Orientation of the program is toward prevention, maintenance, and/or rehabilitation of elderly persons, many of whom suffer from some type of mental impairment (Buckwalter, 1990).

Initial efforts to establish adult day care centers in more rural areas were largely unsuccessful because of geographic distance and lack of transportation, and difficulty identifying and reaching potential clients (Gunter, 1984). Essentially, a few high cost services were provided to a limited number of older clients. More recently, in an effort to overcome these barriers, innovative service delivery systems have been developed and tested to provide social models of adult day care services to sparsely populated rural areas by means of a mobile team of skilled workers, and utilizing the satellite concept that integrates formal and informal social support systems (Gunter, 1984).

Space limitations prohibit detailed analysis of other successful mental health programs for the rural elderly including projects supported by the Ohio Department on Aging's "Elder Care Options"; the Indiana Department of Human Services, Division of Aging Services pilot program called "CHOICE-Community and Home Options to Institutional Care for Elderly and Disabled; The Michigan Office of Services to the Aging's program, "Building Ties"; and the Oregon Senior Services Division's "Senior Mental Health" projects to address the mental health needs of the elderly (Rural Elderly Networker, 1990). The advent of these successful community-based programs specifically designed to serve the mentally ill rural elderly is heartening, and reflects a recent commitment of both federal agencies and private foundations to fund demonstration services research projects targeting this underserved population.

Despite the growth of innovative service delivery programs for the mentally ill rural elderly, there are still many issues related to resources and costs to be considered in the development of outreach mental health services programs in rural settings. For example, Medicare coverage for mental health problems is limited and encourages hospitalization rather than community-based treatment efforts. In addition, issues associated with program image (especially in a highly stigmatized area such as mental health services) and developing supportive relationships with influential rural organizations and religious and socio-political leaders are critical to the success of any outreach effort. To date, grass roots mental health advocacy efforts such as those of the National Alliance for the Mentally Ill (NAMI) and Association for Retarded Citizens (ARC9 have not included the elderly as a priority subgroup. However, increasing numbers of peer counseling, parish nurse, and gatekeeper programs are beginning to address the unmet needs of this population.

In summary, successful models of mental health delivery in rural America exhibit several key features: they are usually multidisciplinary in nature, emphasize geographical appropriateness, promote understanding and utilization of existing lay and community resources, coordinate diverse services, and supportive programs for informal caregivers (Buckwalter, Abraham, Smith, & Smullen, in press) and, in general, serve to demystify mental health care. The following section addresses current public policy and legislative trends that influence the type and extent of mental healths services that are available to rural elders, including the availability of innovative and cooperative services.

PUBLIC POLICY, LEGISLATIVE TRENDS AND ISSUES

Interest groups began lobbying Congress more than 30 years ago, and especially in the 1970's there was renewed interest in health care services for rural America (Patton, 1989). Both the House of Representatives and the Senate established rural caucuses and an Office of Rural Health Policy (DeLeon, Wakefield, Schultz, Williams & VandenBos, 1989). Table 1 summarizes Congressional action on rural health care legislation, which is a backdrop for understanding policy related to mental health issues for the rural elderly).

(TABLE 1 ABOUT HERE)

Historical Overview of Mental Health Legislation

The first large mental hospitals in this country were built in isolated rural areas to provide both work and sustenance for their residents and employees. But it wasn't until after World War II that more comprehensive, community based mental health centers were developed with a focus on preventive mental health care. With regard to legislation specifically related to mental health issues, passage of the Community Mental Health Centers Act (P.L. 88-164) in 1963 was the first federal initiative to develop community-based mental health services and an effort to decrease distances rural clients had to travel for care and follow-up treatment. By 1975 (P.L. 94-63) twelve services were required to be available in order to qualify for federal staffing funds. These services included: outpatient, inpatient, emergency, partial hospitalization, specialized services for children and the elderly, screening aftercare, transitional housing, consultation/education, drug abuse, and alcoholism. Such a comprehensive array of services are not available in most rural areas. Longest, Konan, ar ' Tweed (1979) noted that comprehensive mental health services were available in only 18% of rural catchment areas vs. 26% of the rural areas studied.

In 1977 then President Carter appointed the Commission on Mental Health to review the country's mental health system. The Commission's 1978 report, cited in an earlier quotation, paid particular attention to the maldistribution of mental health services to rural regions and led to passage of the Mental Health Systems Act (P.L. 96-398), which would have aided rural areas. Regrettably, the Budget Reconciliation Act (P.L. 97-35) repealed the Systems Act before it could be implemented. P.L.97-35 combined mental health service funds with block grants allocated for drug abuse and alcoholism, and effectively eliminated money for innovative demonstration projects in the area of service delivery (Walters, 1983). Community mental health services previously funded by categorical grants were henceforth funded by block grants at somewhere between 50-80% of their prior funding level. Over the past decade numerous authors have speculated that the implementation of the federal block grant program to states, with reduced funding and regulation, has adversely affected staffing at rural CMHCs in particular (Estes & Wood, 1984; Orkin, 1984; Stuve, Beeson , & Hartig, 1989; Woy, 1981), and that rural agencies, designed on a generalist model, have suffered more from the effects of block grant funding than urban agencies (Arb & Holcomb, 1985; Hargrove & Melton, 1987).

In 1987, Title IV of the Older Americans Act was amended to support training, education, research demonstration and evaluation projects for long term care, rural transportation and mental health (Atchley, 1991). Social Service Block Grants also became available for home care, adult protective services, adult day care, transportation and nutrition services, adjunct services commonly needed to support the mentally ill rural elderly at an optimum level in the community. More recently, with regard to this special population, Congress has developed and set the process for rural health centers, whose resources and services include: 1) reauthorization of the Older Americans Act and creation of the Agency on Aging as a clearinghouse for information regarding the elderly; 2) the development of non-medical home care programs for frail elderly who are homebound and receiving Medicare; 3) respite care for family members of chronically dependent rural elderly under Medicare; 4) the designing of Rural Referral Centers to coordinate aged community services; and 5) the establishment of essential access community hospitals in seven states to create rural health aging networks as back-up emergency services for rural primary care hospitals.

Over the last three decades, mental health services, in the form of satellite clinics, support groups, public education campaigns, and the establishment of communication networks, have become more available in nonmetropolitan areas. Private service initiatives (e.g. The Task Force for Rural Elderly of the American Medical Association, The American Association of Retired Persons, and Rural Health Care Coalitions) provide information to the rural public on elderly care policy changes and expert advice and resources for the rural elderly (Congressional Masterfile, 1983-1990). However, the current situation is still less than ideal (Buckwalter, 1990). Table 2 provides an abbreviated historical overview of federal laws relevant to geriatric mental health.

(PLACE TABLE 2 ABOUT HERE)

On a larger scale, there is a need to establish a comprehensive rural development policy and a tangible commitment to building mental health programs in rural America, along with redirection of money from custodial care of the elderly to home care and rehabilitation (Walz & Elliot, 1983). Similarly, Medicare and Medicaid reimbursement guidelines require revision so as to no longer discriminate against mental health treatment, especially outpatient services. Coverage should be extended to include CMHC services, unlimited reimbursement to outpatient services, reduction in co-payment percentages, and extension of mental health inpatient coverage comparable to that allocated for physical health problems. Federal policy should recognize the interplay of medical, social and psychiatric problems in the elderly and provide older rural residents with aid in paying for both medical and mental treatment (Walz & Elliot, 1983). Without the support of policy makers, and more effective grass roots advocacy for the elderly (Brown, 1985), even the most innovative and effective mental health programs cannot fulfill their potential.

RESEARCH CHALLENGES IN RURAL GERIATRIC MENTAL HEALTH

Education for, and practice within, rural health settings should be based on research to assure that mental health interventions have the same efficacy for anticipated outcomes as they do in other settings (Turner & Gunn, 1991). To this end, the National Action Commission on the Mental Health of Rural America has urged the NIMH to make rural mental health research issues a higher priority (Bergland, 1988). The situation has improved over the last decade, and more researchers are now investigating various aspects of rural geriatric mental health, thanks in part to federal research initiatives such as the Exploratory Center Grants on the Health and Effective Functioning Of Older Rural Populations, supported by the National Institute on Aging. Our understanding has also been increased by epidemiological data from the Epidemiological Catchment Areas surveys. However, there is still insufficient empirical data documenting the mental health needs of the elderly, a dearth of baseline data on which to base planning, and too little attention paid to regional, socioeconomic, residential, cultural and linguistic differences among the rural elderly in this country.

One problem of research in this area centers on the conceptual and operational definitions of the terms "rural" and "elderly," and the conceptualization and criteria for mental health and mental illness vs. constructs such as "subjective well-being" and "life satisfaction" in this population (Scheidt, 1985). As noted by Lee (1991, p.7), "Because of its diversity the conceptualization and subsequent operationalization of rural is also diverse." This lack of standardization is also true regarding age criterion for studies of older adults, compounded by the lumping of all persons over age 60 into one, allegedly homogeneous group of "elderly," when in fact a 60 year old may be as different from a 90 year old as a 10 year old is from a 40 year old. These ambiguities make interpretation and generalization of findings difficult (Scheidt, 1985), and it is therefore not surprising that statistics and research related to the mental health needs of the elderly rural population vary considerably, often as a function of the definitions used by the researcher. A similar problem with studies on the mental health needs of rural elderly is that reported levels of need fluctuate depending on the locale, and on study methods such as sampling and data collection methods (Kim, 1982). Finally, too few studies have examined rural-urban differences with regard to geriatric mental health issues, or the interaction between age and community size, and those that do have yielded inconsistent results.

Babich (1982) noted that researchers have approached the problem of ascertaining the prevalence of psychiatric problems in rural areas by measuring the "treated prevalence," that is, those already using the mental health system, or by extrapolating prevalence rates from survey findings. Often, mental health survey instruments have been normed on urban populations, increasing the likelihood that poor and ethnically diverse rural populations will be judged as deviant (Babich, 1982). Further, much of the research that has been done on rural residents is based on bivariate analysis. DeLeon et al. (1989) argue that poverty, shortage of healthcare workers, and mental health problems in rural areas are a neglected aspect of health services research. In addition, most studies are cross-sectional in design, which does not allow researchers to determine the direction of hypothesized causal effects. Another problem of much of the research on mental health needs of rural residents is that the samples are such that they are not generalizable to the rural population in general, for example, only persons who routinely use health clinics.

At present there is a lack of research on the quality of geriatric mental health care provided in rural areas that can adequately serve as the basis for equitable and effective policy making. More methodologically rigorous research is needed on the characteristics and problems of older rural residents and mental health providers so that public policy and treatment programs can be more relevant and beneficial (Kim, 1981a). Too often resource development is based on the agendas of Congressmen and interest groups rather than on research. Thus, proposed national and state policies are often based on perceptions of and assumptions about the quality of mental health care that is delivered to older adults in rural areas rather than on documented empirical findings.

In summary, the status of geriatric mental health studies in rural areas is still inadequate to understand the magnitude of the problem, and the extent of need for services for this underserved population. Several solutions have been proposed (Ludke, 1992) including conducting an information synthesis and needs assessment and holding an issues forum to identify, debate and reach consensus on critical issues regarding the quality of rural geriatric mental health services. Invited forum participants, consisting of national leaders in rural, mental health and gerontological issues would address topics such as appropriate standards for rural geriatric mental health care quality, factors that impact upon the availability and quality of rural mental health services, and areas in need of further research.

CONCLUSION

Change is inevitable for the rural health care system, but managing that change requires knowledge, focus, more grass roots advocacy, savvy use of the media, and public relations effort, commitment, supportive community values, hard work and leadership, and better use of lay and local resources (Brown, 1985; Ray, 1991). Geographic and cost factors associated with the accessibility of services and issues related to the stigma of mental illness, cultural norms, and the negative attitudes of some service providers make delivery of mental health services to the elderly in rural settings problematic. Along with the development of innovative and coordinated treatment programs, there is a need for more grass roots advocacy and a greater public policy commitment in order to build a true continuum of community based services and promote a mental health delivery system that will effectively serve this population. More research is also needed so that both services and public policy accurately reflect the needs of older rural residents of this country, as recommended in the next section.

Recommendations for the Future

As clinicians, administrators, program planners, policy-makers, and legislators look at the present to plan for the future, a number of research, service, education, and policy needs demand consideration. The following recommendations reflect the opinions expressed by health and mental health providers, aging service representatives, educators, and program planners from across rural America who participated in the workshop on mental and social needs of rural elderly as part of the planning conference, "Health and Aging in Rural America: A National Symposium," held in San Diego, California, September 21-22, 1992. In each section below, the recommendations presented are a synthesis of the beliefs and priorities of that workshop group. Although recommendations are presented categorically, including research, service, education, and policy needs, it is important to remember that each set of recommendations in intricately related to the others. Thus, there is really no beginning or end; rather, there is a circle of need that requires our attention.

RESEARCH NEEDS

As emphasized throughout this paper, there is a need for research in nearly every area that is relevant to the mental health of rural elderly. As a result, the list of research recommendations is somewhat longer than other areas, reinforcing the workshop group's belief that policy, education and training, and services for rural elderly should be based on factual, research-based information. The following recommendations reflect, in order of priority, the needs identified by the mental and social health workshop group.

1. Research that addresses social, demographic, and environmental factors that influence the mental health of the rural elderly is needed. Issues of particular interest and concern include the following:

   -- assessment, service delivery, and other areas that may be unique to different minority groups;

   -- on-going investigation of gender differences among rural elders;

   -- the development of data based vignettes that provide updated profiles of rural elders who have mental illness.

2. Given the observed rate of under-utilization of mental health services by rural elderly and the effect stigma and other barriers to care, further research is needed on: rural values and the role those value systems may play in impeding or facilitating service use; attitudes about and perceptions of mental health held by rural elderly; and the effect those attitudes and beliefs may have on actual use of mental health services.

3. The incidence and prevalence of mental illness among the rural elderly clearly deserves on-going attention in the research community. Both epidemiological and descriptive studies are needed to further characterize and clarify the primary needs of this group.

4. More research is needed on the role of natural support systems and informal networks in geriatric mental health. Likewise, studies are needed to determine the most effective ways that health, mental health, and other service providers can work with these naturally occuring systems and networks.

5. Because a substantial portion of geriatric psychiatric care is provided by general practice or internal medicine physicians, investigation of the diagnostic and treatment decisions made by primary care physicians is needed.

6. Given the type and extent of barriers to providing mental health services to rural elderly, further research into the matters of ageism, lack of trained mental health professionals, stigma, and other identified barriers to care is indicated.

7. Research is needed on the outcomes of service delivery linkage models that link geriatric health and mental health services in rural areas.

8. More studies are needed on the costs associated with the delivery of appropriate geriatric mental health services to rural elderly, particularly ones that take into consideration both individual and program needs. Incentives should be established to promote utilization of the most cost effective mental health services for older persons in need.

9. There is a need to develop and test theoretical models that are applicable to mental illness among elders residing in diverse rural areas.

10. Differential research between urban and rural areas based on the cultural mix of mental health providers, funding, and methods utilized to provide mental health care to rural elders is needed.

11. A research agenda is that examines the life-long experience, current circumstances, emotional, physical and social nature of rural life as they affect mental health, well-being and functioning of nonmetropolitan residents in later life is needed. Examples of research questions to be addressed include, but are not limited to:

    -- What accounts for differences between older rural and urban residents in their concentration in particular regions of the country?

    -- What are the consequences of such concentration for the provision and utilization of geriatric mental health services?

    -- How does the poverty of older rural people affect their mental health, well-being, functioning, and service use?

    -- What impact does less education have on their mental health and functioning?

    -- What are the forces influencing the recruitment and retention of mental health personnel willing and able to work with the elderly in rural areas?

    -- What are the characteristics of mental health professionals who choose to remain and practice in nonmetropolitan CMHCs, and how are they different from those who leave their positions?

    -- How can limitations (such as transportation) that affect the quality and availability of geriatric mental health services in rural areas be offset?

    -- What factors restrict the use of mental health services by older adults in rural areas?

    -- Who is able to use particular services and under what conditions?

    -- How does lack of information about mental health treatment, prevention or the existence of geriatric mental health services influence appropriate utilization of services by older adults?

    -- How do the attitudes and beliefs of older rural residents affect utilization of mental health services?

    -- How does the practice of folk medicine influence use of mental health treatment by this population?

    -- How does the strength and frequency of social ties and interaction in rural areas affect mental health, well-being and functioning in later life, including institutionalization rates?

12. Establishment of a program of multiple rural mental health research centers at several sites with access to older rural populations (especially minority populations), and using multidisciplinary teams and multiple research methods. These geriatric rural mental health centers would work in conjunction with programs of investigator-initiated research, as a means for conducting epidemiological research and developing research initiatives on the mental health of older rural populations. These centers should pay particular attention to research the will assist in improving the quality and accessibility of geriatric mental health services in rural areas, and support longitudinal studies on the evolution and interaction of formal and informal sources of care (Dwyer, Lee & Coward, 1990).

SERVICE AND PROGRAM NEEDS

As highlighted throughout this paper, a wide variety of needs exist in the arena of service delivery and program development. Currently, few specialized services exist to address the diverse needs of rural elderly. Most rural communities are able to provide only basic services due to the scarcity of financial and human resources. As a result, the mental and social health workshop group generated a number of recommendations for the development of services and programs to serve the rural elderly. In order of priority, those recommendations include the following.

1. Develop, implement and systematically evaluate innovative service models that utilize existing primary care, public health, and mental health services. Ideally, these models should

   -- overcome physical, geographic and psychological barriers that currently impede effective delivery of mental health services to the rural elderly;

   -- identify and incorporate key components of successful mental health service programs for rural elderly; and

   -- focus on the development and refinement of outreach models to serve rural elders.

2. More and creative linkages between existing services, agencies, lay resources, and community groups is needed. Mechanisms to improve communication, accessibility, and utilization of existing health and mental health services is needed. This may include, for example, use of case management programs and training of caregivers and service providers about supplemental service agencies commonly needed by the elderly (e.g. homemaker/home-health aides, visiting nurses, home-delivered meals, transportation services, etc.) and how to access these agencies.

3. In spite of the dearth of material and human resources in rural communities, the goal should be to provide a true continuum of mental health care, ranging from preventive services to illness treatment.

4. Access to diagnostic evaluation and development of minimum standards for assessment and diagnosis of geriatric mental health problems (including dementia) among non-psychiatric providers in rural areas must be improved. For example, traveling diagnostic clinics could be established and coordinated through local health care professionals. Supplementary funding must be made available to older persons without insurance who cannot avail themselves of proper diagnostic and treatment services.

5. The development of "user friendly" services that encourage easy access to existing services. Statewide clearinghouses should be established including an 800 telephone line to afford older rural residents and their families easy access to information related to mental health promotion, mental illness, diagnosis and treatment, referral to and availability of services, legal and ethical issues, educational information and programming, crisis management, and studies and reports related to geriatric mental health and illness. These services should promote interstate connectedness and assistance with long distance caregiving.

6. States should develop guidebooks to assist rural families with the complex legal and ethical issues that confront older victims of mental illness and their families (e.g. guardianship, conservatorship, power of attorney, etc.). These guides should insure the older adult personal autonomy while at the same time provide for appropriate legal decision making.

7. Because rural elderly are becoming increasingly diverse in terms of culture and ethnicity, services must be sensitive to the unique beliefs, values, and needs of minority populations served within individual communities.

8. In addition, services that promote consumer choice and preference are needed.

EDUCATIONAL AND TRAINING NEEDS

Another predominant theme throughout the workshop discussion group was the need for education and training: among mental health professionals, health and social service care providers, general practice and internal medicine physicians, the elderly themselves, their families, and the community at large. Needless to say, the need for training and education is extensive. The mental and social health workshop group identified the following needs, again listed on the basis of their priority.

1. There is an clear and on-going need for increased educational programming on geriatric mental health issues for both formal and informal care providers in rural settings. Curriculum changes should be encouraged in medical and nursing schools and in social work and psychology programs to enhance geriatric mental health knowledge, especially in the areas of diagnosis, medication management, and care of older rural residents with mental health problems. Likewise, education and training programs should be developed and offered to front-line providers, those who work with rural elderly on a day-to-day basis and have the greatest opportunities to influence the outcome of their care.

2. Practical experiences and mentorship opportunities for both graduate and undergraduate students in the arena of mental health in rural areas are clearly needed. Curriculum changes that emphasize rural health care, as well as practicum and clinical opportunities like that offered by the University of Colorado's nursing program, are need to increase the probability of clinicians practicing in rural areas.

3. Public (community) information and education about mental health and illness issues are needed, including but not limited to issues relating to prevention, symptom identification, diagnosis and treatment of mental illness. For example, geriatric mental health educational programming in rural areas should include the provision of accurate information about what mental illness is and is not, and emphasize the value of early identification and treatment. Comprehensive geriatric mental health education should include elements of prevention, planning, and the use of community resources and services.

4. Interdisciplinary training between health professions is needed to increase awareness and understanding of what each discipline and/or service contributes to the arena of mental health and illness management.

5. Education and training programs should be age, culture, and gender sensitive. Likewise, these programs should address "sensitive" topics such as sexuality in the aged. Both academic curriculum and continuing education programs need to incorporate information that addresses the increasing diversity among rural elders, including demographic information, unique characteristics of specific local or regional groups, and methods to enhance assessment, treatment, and service utilization by minority populations.

6. Retreats should be organized for provider groups to meet in a "think tank" format with the leaders of national coalitions and networks (e.g., National Coalition of Agencies) to examine, discuss, plan, and advocate for increased mental health services in rural areas.

7. Seminar series that address key issues related to the mental and social health of rural elders should be developed and offered to legislative staff in the effort to increase their awareness of both problems and proposed solutions.

8. National and local media attention should be sought to increase the awareness of both the need for rural mental health providers as well as the advantages of working in rural areas. The National Ad Council may be utilized as one such mechanism for the recruitment of professionals to underserved rural settings.

9. Relabeling of resources is needed to decrease stigma associated with mental illness, and research is needed to evaluate the effect of relabeling e.g. "counseling vs. psychotherapy; adjusting to the later years vs. geropsychiatric services" on service utilization patterns among the rural elderly and their caregivers. Geriatric mental health services and educational programming should utilize low threat approaches.

POLICY LEGISLATIVE NEEDS

As noted before, the recommendations made here are continuous and interactive rather than discrete. Changes in all areas are needed to truly effect change for rural elders. However, the area of policy related to the development and maintenance of mental health and illness services, training of geriatric psychiatric professionals, and funding of research is of paramount importance. The mental and social health workshop group recommended that attention be paid to the following issues.

1. The goal of reducing competition, and increasing cooperation and linkages between aging and mental health services, must begin at the Federal level. Joint programs and funding streams are needed to enhance cooperation between agencies and services at the State and local levels, a goal which can be achieved by way of language, legislation, and appropriations that demand inter-agency cooperation and build on local resources. Greater communication and cooperation among all levels of government, advocacy groups, and providers is needed to establish and maintain a comprehensive mental health care system in rural America.

2. Commitment of local, state, and federal funding bodies to provide ongoing support for effective rural geriatric mental health projects is essential. State and federal planners must reexamine existing policies and review methods, particularly the Medicare reimbursement structure's effectiveness in rural settings, the need for more lenient reimbursement policies for homecare, and funding to sustain successful service delivery programs.

3. Definitions of mental illness must be reexamined in light of current realities about elderly individuals. Specifically, the definition of chronic or severe mental disorder, which is focused on chronicity that begins early in life (e.g., schizophrenia), rather than the chronicity of illness that may begin in later life (e.g., dementia, alcoholism, depression), needs to be examined and revised. The onset of mental illness in late life can be equally, if not more, disabling and limiting than illness that occurs for the first time in youth.

4. Health care reforms must include provisions for delivery and reimbursement of mental health and illness treatment, a long neglected matter that is paramount to the provision of mental health services to rural elderly. One such mechanism is the provision of tax credits to rural family caregivers.

5. Given the dearth of psychiatrists in rural settings, efforts should be focused on increasing the number of primary care providers (e.g., general practice and internal medicine physicians) who are sensitive to and knowledgeable about the mental health and illness needs of rural elders.

6. Standing legislative advisory groups on geriatric mental health should be established in rural areas to tackle specific issues, develop ideas for change, and identify solutions on an intensive, long term and single issue focused basis.

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Table 1
Rural Health Care Legislation

Date	Action
1966	The appointment of the National Advisory Commission on Rural Poverty by President Johnson (Chronology, 1967, p. 578).
	Community health centers were established to focus on the health needs of rural people (Chronology, 1967, p. 578).
1970	Title IX Rural Development -- planning, technical and financial assistance were designed to assure a sound balance between rural-urban communities (Chronology, 1970, p. 339).
1972	S 1163-PI 92-258 Amendment to the Older Americans Act of 1965 (PL 89-73) ...Nutrition for Aged (Chronology, 1972, p. 352).
1977	Rural health clinics designed to improve health care services in medically underserved rural areas (HR 8422 - PL 95-210). This law requires physicians, nurse practitioners and physical assistants to work together and develop an effective referral rural health care system (Chronology, 1978, p. 615).
	Health Service Centers -- Primary care grants to be awarded to states to assure equitable urban-rural distribution of monies (Chronology, 1978, p. 617).
	Older Americans Act of 1965 extended services to vulnerable elderly population (Chronology, 1978, p. 694).
1980	Block Grants -- Shifted dollars to states; Community Service Block Grants.
1986	Congress reauthorizes Older Americans Act to create an Administration on Aging (AOA) to service as a clearinghouse for information on the problems of the aged, administer grants, and provide technical assistance to states and local governments (Congressional Quarterly Almanac, 1987, p. 511).
1987	Congress authorizes $25 million for 1988, $26.3 million for 1989, $27.6 million for 1990 and $28.9 million for 1991 for grants for non-medical home care for the frail elderly (Congressional Quarterly Almanac, 1988, p. 512).
	Respite care for the chronically dependent community elderly was authorized by Congress to provide coverage of up to 80 hours per year of paid care to an unpaid family member or friend who lived with the dependent elderly (Congressional Quarterly Almanac, 1988, p. 284). In order to qualify for benefit, the Medicare beneficiary had to exceed either the Part B out-of-pocket cap or the prescription drug deductible and be unable to perform three activities of daily living (Congressional Quarterly Almanac, 1988, p. 291).
	The Secretary of Health and Human Services was required to study out-of-home services, such as adult day care, and report to Congress within 18 months (Congressional Quarterly Almanac, 1988, p. 96).
1988	Rural Referral Centers were grandfathered through fiscal year 1991 (Congressional Quarterly Almanac, 1989, p. 96).
1989	Home and community based elderly care service programs were designed to provide in-home services for the functionally disabled using Medicaid funds (Congressional Quarterly Almanac, 1990, p. 147).

Table 2

The following brief historical overview of federal mental health laws provides a basic premise for understanding the contemporary status of the CMI elderly and nursing home placement.

Federal Mental Health Laws

1948	The National Institute for Mental Health was established by Congress (McCausland, 1987).
1955	Congress passed the Mental Health Study Act. The Act authorized the first study of the human and economic problems of the mentally ill. "Action for Mental Health" was the final report that provided the framework for the radical changes of the mental health movement (McCausland, 1987).
1963	The Community Mental Health Centers (CMHC) Act was passed by Congress. PL 88-164, Title II, authorized $150 million over fiscal years 1965-67 for states to pay for construction of public and private, non-profit community mental health centers for the prevention, diagnosis, treatment and rehabilitation of mentally ill patients in their own communities (deinstitutionalization). The grants were to be allocated according to population, need for centers and financial need (Schroth, 1945-1964).
1965	Congress amended the Community Mental Health Act of 1963 (PL 88-164). This act authorized a new seven-year program of grants (fiscal 1966-72) to public and non-profit private agencies to help pay for the initial costs of professional and technical personnel at community mental health centers (Dickinson, 1965-1968).
1970	Congress extended the CMHC Act through fiscal 1973 (S2523 - PL 91-211). S2523 provided new aid for mentally ill children and centers in poverty areas (Diamond, 1979-1980).
1975	CMHC sought federal funds for initial operation to provide the following services within two years of receipt of the funds: inpatient, outpatient, day care and partial hospitalization, emergency, and specialized services for children and the elderly, consultation and education services including assistance to courts and other public agencies, and half-way house services for those discharged from a mental institution; the Act also required the centers to provide services for those abusing alcohol or drugs if the community needed such services (O'Connor, 1973- 1976).
1980	Congress passed the Mental Health System Act (S1177 - PL 96-398) which increased funding for mental health services in fiscal years 1981-84, totalling $796 million. Also, the Act expanded those services to groups that traditionally had been inadequately served by the existing mental health care delivery system (Gotton, 1977-1980).
1982	New grant programs were developed for the chronically mentally ill ... those that were considered unlikely to ever be cured ... Elderly, other priority groups: Congress authorized grants for projects serving certain "priority populations" that did not have access to adequate mental health services. At least 40 percent of the funds were reserved for projects serving the elderly ... Congress recommended a model for mental health patients' "bill of rights" for states to adopt on a voluntary basis; establishment of innovative projects for the training and retraining of personnel; authorized grants for mental health prevention and demonstration projects (Gotton, 1977-1980).
1983	The Reconciliation Bill required states in fiscal years 1982-84 to continue funding each CMHC that received federal funds in fiscal year 1981 (Cohn, 1981-1984).

Table 2 (Continued)

1986	Congress passed S974 - PL 99-319 to create new legal protection and advocacy services for the institutionalized and recently discharged mentally ill ... S974 extended to the mentally ill protection and advocacy services already available to the "developmentally disabled" under a 1975 law that was reauthorized in 1984 (PL 98-527) ... PL 99-319 was developed because of increasing reports of abuse and neglect of patients in state mental institutions (Cohn, 1986).
1987	Congress passed the Budget Reconciliation Act (HR 3545 - PL 100-203). The Act provided tougher rules for nursing homes that participated in Medicare and Medicaid programs. Part of this ruling was to meet the patients' mental and social needs; the establishment of a quality assessment and assurance committee that met at least quarterly; that written care plans were completed upon admission, describing the medical, nursing and psychosocial needs of the resident and how the needs would be met ... The Act also required that a nursing home could not admit a mentally ill or retarded person if it could not provide quality care within its facility, the nursing home could arrange with others, such as physicians, nurses, specialized rehabilitative services, to meet the physical, mental and psychosocial needs of the residents (Lawrence, 1987).
1989	PL 100-203 required the Department of Health and Human Services to propose regulations on pre-admission screening programs to prevent mentally ill or retarded people from being inappropriately placed in nursing homes (Lawrence, 1989).
1990	The "federal government requires the professional caregivers to identify persons with serious mental illness and provide them with case management (PL 99-660)" (Knisley, 1990, p. 1).

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The Gerontologist
Vol. 31, No. 3, 408-412

This paper describes an elderly outreach program (EOP) designed to identify and provide mental health services to the rural elderly. The project integrates a variety of health, mental health, and human service agencies in the planning and delivery of services. Five referral sources are identified and described as well as the assessment, treatment, and referral process. Outcomes are discussed in terms of: characteristics of persons served, ability of the project to identify and deliver mental health services, treatment effectiveness, and cost effectiveness of the project. The EOP seems to have prevented an increase in need for mental health care among Iowans that might have occurred in the program's absence.

Key Words: Rural services, Geriatric mental health

Mental Health Services of the Rural Elderly Outreach Program[1]

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Introduction

The number of elderly persons in Iowa's rural areas has increased dramatically over the past decade, and elderly mental health services have become a recent priority statewide. Several barriers, however, have impeded the effective delivery of services, including inadequate number of staff knowledgeable in psychogeriatrics, limited service delivery models, and a lack of coordination among mental health, medical, and aging and human service providers. In an effort to overcome these barriers and to identify the mental health needs of the rural elderly, the Abbe Center for Community Mental Health of Cedar Rapids, Iowa, in cooperation with the Heritage Agency on Aging, developed an outreach program in 1986 to identify and deliver outpatient mental health services to the rural elderly.

In this rural elderly outreach program (EOP), persons in need of mental health, medical, and social services are identified through a combination of five approaches (described in detail later in this paper). Following referral, a multidisciplinary outreach team conducts comprehensive in-home mental health evaluations, then implements and coordinates an appropriate treatment plan, including referrals to medical and social service agencies. Services are provided to mentally impaired elderly either through existing service delivery mechanisms or home-based care.

Need for the Rural Elderly Outreach Program

The rural elderly population is vastly underserved by the mental health system, and rural residents have unique mental health service needs. The rural elderly account for only a small percentage of community mental health center patients nationally and less than 7% of the caseload of private psychiatrists (Kermis, 1987). Community mental health centers in rural areas serve proportionately fewer elderly than centers in more urban areas. Recent studies have estimated that although a significant number of the elderly have mental health problems, their treatment needs have not been adequately addressed (Lebowitz, Light, & Bailey, 1987; Raschko, 1985; Smyer & Pruchno, 1984; Spore & Atchley, 1990).

Thus, there is a need to reach a greater percentage of the rural elderly in order to identify and attract those persons in need of mental health services. Effective mental health service delivery in rural America requires innovative approaches, including coordination and cooperation among mental health, medical, and social service providers. The delivery system must maximize limited resources, address community needs, provide continuity of care, and use professional, paraprofessional, and lay personnel appropriately (Palmer & Cunningham, 1983).

Because of limited services available in rural areas and because many rural Americans are reluctant to accept services even where they are available, care alternatives are often restricted to crisis intervention or long-term institutionalization. These problems can only be expected to proliferate as the number of rural elders increase and experience life changes and

[1]Supported by grant #07AM0310-02, Administration on Aging; #87-001-413-0413-2464-06, State of Iowa Department of Mental Health, Mental Retardation and Developmental Disabilities; and #87-001-413-6920-2464-01, The National Institute on Mental Health. We thank Teri McDaniel and Nancy Goldsmith for assistance in preparation of this manuscript, and Russell Profitt, Pat Kudart, Teri Schafer-Nelson, Kathy Chivalisz, Dianne Springer Brenoaman, and Alan Whitters for implementation and evaluation of the project.

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situational stressors, such as the farm economic crisis, known to precipitate mental health problems (Preston & Mansfield, 1984). Further, geographic and cost factors associated with the accessibility of services plus cultural norms and the stigma of mental illness can make delivery of mental health services in rural settings problematic (Krout, 1986).

Outreach programs have been suggested as one effective approach in delivering services to the elderly, because those most at risk do not present themselves to mental health and social service agencies (Jamieson, Campbell, & Clark, 1989; Raschko, 1985; Yedidia, 1990). Outreach efforts have proved helpful in treating urban elderly who might not otherwise enter mental health programs until a crisis necessitates hospitalization (Wasson et al., 1984). Evaluations of these programs suggest that they provide rapid and effective mental health assessment and treatment, and minimize disruptions due to premature institutionalization (Reifler et al., 1982).

The effectiveness of outreach programs for the rural elderly, however, has not been adequately tested. Service providers must understand and be sensitive to the rural value system and social ecology of the area to avoid addressing assumed rather than real needs. Imposing successful urban techniques, such as outreach programs, without modification in rural settings may be neither appropriate nor effective.

Overview of the Program

The EOP was designed to identify individuals in need of mental health care, to deliver needed services, and to initiate and coordinate referrals to appropriate medical and social services agencies (Buckwalter et al., 1988). The EOP takes services to the people most in need of them — the homebound rural elderly — and addresses another service delivery problem common in rural areas, the scarcity of mental health professionals available to identify and treat the elderly.

Referral Sources

As shown in Figure 1, our model is composed of five referral sources. Each of these is discussed below.

Referral Source I: Onsite Psychosocial Screening. — At community settings such as well elderly clinics, churches, and congregate meals, EOP nurses administer a battery of psychosocial assessment instruments (The Geriatric Depression Rating Scale [GDS], The Short Portable Mental Status Questionnaire [SPMSQ], and The Short Psychiatric Evaluation Schedule [SPES]) that can be completed in less than 30 minutes and that screens for depression, cognitive status, and psychosis.

Referral Source II: Case Management. — An established interagency case management network includes 14 elderly health care and social service provider agencies. Informational sessions were held for each of these agencies to explain the EOP and to foster coordination of services. The EOP social worker serves as the liaison to the case management network participants and meets with them twice a month to discuss clients with mental health problems who may need multiple services.

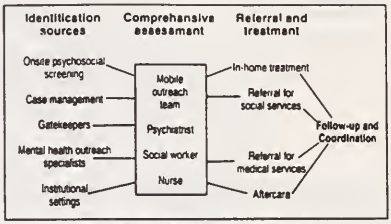

Figure 1. Model used in the Rural Elderly Outreach Project.

Referral Source III: Gatekeepers. — Nontraditional referral sources, gatekeepers, are people who reside or work in the rural community and who, in the course of their regular activities, come into contact with the elderly. As gatekeepers, they find and link isolated older people with sources of needed help. The gatekeeper approach, modeled after Raschko's (1985) project in Spokane, Washington, organizes the fabric of the rural community itself and brings forth the people who most need help. This approach assumes that both the agency and community are problem-solving partners (Lidoff, 1984).

Gatekeepers are not expected to be case workers or counselors or to do anything beyond their ordinary activities. Rather, they are asked to be alert to signs that an older person may be ill or in trouble. Gatekeepers include, for example, rural mail carriers, veterinarians, extension service workers, utility workers, and farm implement and grain dealers. They have in many cases enjoyed lifelong contact with their elderly neighbors and may therefore be more sensitive to changes in personality and habits indicative of mental illness. They also have more direct knowledge of existing social support networks and consequent social isolation.

The EOP has trained more than 500 gatekeepers to locate, identify, and follow high-risk elderly who would not self-refer or who are without family or friends to act on their behalf. A two-part gatekeeper training manual was developed to accompany the training sessions. Part I, "Introduction to the Gatekeeper Role," presents an overview of the gatekeeper role, including indications for referrals, follow-up and feedback, and information on how to recognize symptoms of emotional disturbance in the elderly. The 30- to 45-minute Part I training program and accompanying manual are intended for use by nonmental health professionals and a wide variety of community members. The 2- to 3-hour Part II training program and accompanying manual, "Specific Disorders, Signs and Symptoms," provide an overview of

mental illnesses commonly found among the elderly, as well as definitions of terms and frequently occurring signs and symptoms. This training is separate from and builds upon information presented in the Part I program, and is intended for use by elderly service providers and health care professionals (e.g., public health nurses).

Referral Source IV: Mental Health Outreach Specialists. — Four mental health outreach specialists were assigned to community-based agencies serving the rural elderly. These half-time specialists (two baccalaureate-prepared nurses and two social workers): identify and recruit community gatekeepers; conduct gatekeeper training sessions; engage in outreach and case-finding activities; provide mental health assessments and referrals to the EOP team; serve as a resource to agency staff by increasing their knowledge and case planning skills in the mental health area; and collaborate with EOP team members to provide educational and staff development programs in their assigned agencies and the rural community at large. Each specialist is supervised by a member of the EOP team and meets weekly with their supervisor to discuss referrals and assessment services.

Referral Source V: Institutional Settings. — To heighten awareness of the project and enhance aftercare referrals, the EOP social worker met regularly with discharge planners from all hospitals and psychiatric facilities serving the catchment area. Those rural elders under the care of a private psychiatrist or discharged to another institutional setting (e.g., nursing home) are generally not referred to the outreach project unless a request is received from the attending physician.

Criteria for Referral

To be eligible for assessment and treatment by the EOP, persons must be over age 55, reside in the mental health catchment area, and be noninstitutionalized. Persons in nursing homes are eligible for evaluation only if they have potential for outplacement in the community. All referrals are evaluated and eligibility determined by the mobile outreach team.

Assessment and Treatment

Elderly persons at risk for mental health problems as identified by any of the five mechanisms (see Figure 1) are referred to the elderly outreach project at the Abbe Center for Community Mental Health. The EOP team is composed of a part-time psychiatrist, and a full-time geropsychiatric nurse, a geriatric nurse practitioner, and two geropsychiatric social workers. Initially a fourth-year psychiatric resident from the University of Iowa was hired for 10–12 hours per week to provide diagnostic and medication support on weekends and evenings. After termination of grant funds, the Abbe Center medical director assumed psychiatric responsibility for the team. The Master's-prepared geropsychiatric nurse and social workers were recruited out of University-based graduate programs in their respective disciplines, although all had prior clinical experience working with the elderly. The geriatric nurse practitioner was recruited from the local visiting nurses' association and received on-the-job training as well as formal coursework in mental health. The EOP concept is truly collaborative and emphasizes interpersonal as well as interdisciplinary respect. The team approach provides both structured and informal opportunities for open discussion and case consultation. This collaborative approach may contribute to the fact that there has been no staff attrition since inception of the EOP in 1986.

The multidisciplinary team conducts an in-home comprehensive mental health assessment and evaluates the elderly individual's environment, social support network, economic status, and stressors. The assessment also evaluates functional capacity for self-care and quality of interpersonal relationships, as well as ability to remain in the community. Unless recent information is available, the elderly person's physical health status is assessed by the team's geriatric nurse practitioner or psychiatrist, as concomitant physical illnesses are often present that can exacerbate or predispose to mental health problems. Frequently, referrals for laboratory work and comprehensive medical evaluations are made to local family practitioners or a nearby geriatric assessment clinic.

EOP team members meet every other week to discuss all new and selected continuing patients. The purposes of these team meetings are to: develop a coordinated treatment plan for each patient with a psychiatric diagnosis; assign primary responsibility for case management to one outreach team member; systematically assess patient progress and evaluate the treatment plan on an ongoing basis; and determine appropriate "discharge" from the active treatment model and coordinate referrals for inpatient care or continued community support for both patients and their families.

Project Results

Project Implementation

The EOP basically continues to follow the model set forth in Figure 1. Changes that have occurred over the past 3 years are due to increased community demand for the EOP services. In addition to individual mental health assessment and treatment, several programmatic services are now provided through the EOP. For example, geriatric education and mental health promotion activities are provided on a regular basis, and the EOP operates a peer counseling program that provides training and supervision for peer counselors. Caregiver support groups, led by EOP staff, work closely with the geriatric assessment clinic at a local acute care hospital, and staff members have been called in as consultants with

regard to Level II assessments for nursing home admission or treatment.

Project Evaluation

An independent evaluation of the effectiveness of the outreach program was conducted by the Center for Health Services Research at the University of Iowa. In evaluating the EOP, four main issues were examined: characteristics of clients served by EOP; the ability of the program to identify and deliver mental health care to elderly individuals in the community who are in need of services; effectiveness of EOP services; and costs of the EOP. Detailed evaluation findings are available from the first author and are also provided in the final report of the project, submitted to the National Institute of Mental Health (Buckwalter & Russell, 1989).

Characteristics of EOP clients are shown in Table 1. The majority of EOP clients were between the ages of 65 and 85, female, widowed, and a plurality of the clients lived alone. A wide variety of mental health problems were found, the most common of which was depression (15.2% of the clients). Other more common mental health problems included dementia, adjustment disorders, and problems in living. Approximately 25% of the EOP clients reported previous mental health treatment. These characteristics suggest that, in general, EOP clients had been fully functioning in the community until suffering from a physical deterioration or a loss of previous social support resources such as a spouse. These people might not have been identified through more traditional channels as needing mental health care.

The second issue addressed by the evaluation was whether the EOP was serving a population representative of the catchment counties or a specific subset of persons living in those counties. The EOP was designed to serve clients who would generally fall through the cracks with regard to mental health treatment. A comparison between demographic characteristics of EOP clients and census data for the catchment counties indicated that EOP clients represented a group different from the general public. Clients tended to be older, female, widowed, and living alone rather than with family and friends.

With regard to the program's ability to identify need and deliver services, it was hypothesized that the number of people in need of mental health services would decrease in the EOP catchment counties after the program had been implemented compared with two matched control counties. Prior to implementation of the EOP, however, statistically significant differences in need for mental health services were found between the experimental and control counties, with greater need for care in the treatment counties. After implementation of the EOP for a 2-year period, no differences were found between the two geographic areas in need for care. Analyses of changes over time indicated no differences in need for care in the experimental counties, whereas there was a significant increase in need for care in the control counties over time. These results suggest that the EOP may have been effective in preventing an increase in need for mental health care among residents of the experimental counties that might have occurred in the absence of the program.

Table 1. Demographic Characteristics of Elderly Outreach Program Clients, Linn and Jones Counties, Iowa.

	Clients		Residents	
Characteristic	*n*	%	*n*	%
Age				
55–64	51	13.3	16,430	45.4
65–74	133	34.7	11,268	31.2
75–84	138	36.0	6,415	17.7
85 and older	61	16.0	2,072	5.7
Sex				
Male	122	29.0	15,606	43.0
Female	298	71.0	20,691	57.0
Marital status				
Single	27	7.0	2,052	5.7
Married	133	34.6	23,445	64.6
Widowed	187	48.7	8,830	24.3
Divorced/separated	37	9.6	1,970	5.4
Living arrangement				
Alone	219	43.4	8,036	22.1
With family/friends	171	42.4	26,641	73.4
Residential care facility	11	2.7	1,534	4.2
Other	2	0.5	86	0.3

Effectiveness of EOP services was evaluated by interviewing 30 clients prior to initiation of treatment and 4 months later. Analyses of changes in scores on the screening measures (i.e., GDS, SPMSQ, and SPES) over time indicated significant improvements in depression and other psychiatric symptoms. Findings with regard to these interviews should be viewed cautiously in light of the small sample size. In addition, the measures used are screening tools designed to detect the possibility of a diagnosable mental health problem. Measures such as these may not be sensitive enough to be appropriate measures of treatment outcome.

Evaluation of the cost of EOP services indicated that the EOP provides mental health services at a substantially lower cost ($622.29 per patient per year) than that reported by a group of local mental health service providers. Further investigation is required, however, before decisions are made with regard to who should be receiving funding to provide mental health services on the basis of these findings. The group of providers sampled was small and may not adequately represent all possible providers of mental health services. In addition, the exact nature of the services provided needs to be determined in order to examine comparability of the cost figures. At this point, the EOP appears to represent a more cost-effective method of providing mental health services to the elderly.

The EOP's greatest successes have involved educating persons in the catchment area with regard to the mental health needs of the rural elderly. The project has expanded to include a wide variety of outreach activities in addition to those originally proposed. Many groups and individuals in the communities served by the EOP continue to contact the program

for training and consultation. Large numbers of community members have been involved directly as gatekeepers or other types of referral sources. Nursing and social work students as well as family practice residents have gained a great deal of practical experience and education through clinical and research internships with the EOP (See Appendix).

Recommendations

Evaluation efforts are continuing. As more individuals come into contact with EOP services, significant effects will be more easily observed in more objective outcomes such as admissions to institutions and Medicaid expenditures. More rigorous attempts to evaluate EOP services will also be made. For example, treatment outcome studies will provide more information with regard to the effectiveness of services, and services provided by the EOP will be compared with those of other mental health providers to determine whether the EOP is providing a different type of service or delivering similar services in different ways. This information will be helpful to both local and national policymakers, as well as service providers.

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Appendix

Project Accomplishments: First Two Years

- 420 new rural elderly in need of mental health services identified
- 412 comprehensive in-home mental health evaluations conducted
- 97 gatekeeper training sessions held
- 232 previously untreated elderly enrolled in community-based mental health treatment programs
- Aftercare services provided to 62 rural elders following institutionalization
- 215 referrals made by EOP staff to medical and social service agencies
- 377 Gatekeeper Training Manuals disseminated
- Computer training sessions developed and implemented to electronically link community-based services providers with EOP
- Research and clinical internship experiences provided to 32 undergraduate and graduate nursing and social work students from local colleges and universities; 57 fellows and summer institute participants from the Iowa Geriatric Education Center site visited the program, 12 family practice residents rotated through the program
- Widespread referral base established through the case management network, the outreach specialists assigned to four community agencies, and over 550 gatekeepers trained
- Common data base, computer networking, communications, and evaluation systems established among eight community agencies involved in the EOP
- 22 informational sessions held with representatives from community-based organizations in nearby counties to explore new referral sources and disseminate the EOP model to rural areas lacking mental health services for the elderly
- 33 new screening sites identified within the catchment area, and 16 potential screening sites identified in nearby counties
- Procedure manual, worksheets, and training modules developed for the EOP
- Copies of the gatekeeper training video distributed to community education programs, and gatekeeper identification cards given to all trained gatekeepers
- Meetings held throughout the project period with representatives from the state departments of mental health and aging to review project objectives and enhance coordination efforts
- 63 informational sessions related to the EOP held with agencies and civic and religious leaders
- 25 national presentations, 68 local and regional presentations made by EOP staff to disseminate project information and enhance service provision
- Peer counseling program established, with 20 counselors trained by EOP staff
- Community caregiver support group implemented by EOP staff
- Computerized geriatric mental health bibliography established as part of the EOP resource center, consisting of audio and video tapes, books, and periodicals
- Case management network established in a nearby county with assistance of EOP staff
- EOP staff assisted with coping groups at a local adult day center, and were instrumental in the establishment of a psychiatric unit at that center
- Other grants received to expand EOP services in the areas of geriatric mental health consultation/education and providing services to the homeless
- EOP staff participated in a statewide case management demonstration project to examine assessment, referral, and management of the frail elderly

Mental Healthcare For Rural Seniors

An Outreach Program in Cedar Rapids, IA, Uses An Integrated Approach to Break Down Barriers to Care

BY MARIANNE SMITH, RN, & KATHLEEN C. BUCKWALTER, RN, PhD

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Many elderly Americans, especially those living in rural areas, do not receive needed mental healthcare services because several barriers prevent them from doing so. In the Cedar Rapids, IA, area the Abbe Center for Community Mental Health is attempting to eliminate these barriers.

The Elderly Outreach Project (EOP) was introduced in 1986 to provide mental health services to the rural elderly in a two-county catchment area in southeast Iowa. The project uses a multidisciplinary team (psychiatrist, nurse, and social worker) to assess and treat homebound clients, and it integrates a variety of healthcare, mental health, and human service agencies in planning and delivering mental health services.[1]

Background

The EOP was implemented with the assistance of three-year grants from the National Institute of Mental Health (NIMH) and the Administration on Aging and support from the Iowa State Department of Human Services Division of Mental Health, Mental Retardation and Developmental Disabilities. After staff at the Abbe Center for Community Mental Health identified a need for alternative services to reach the elderly, it developed the program in collaboration with the Heritage Area Agency on Aging.

Staff recognized that older clients were not coming to the center for assistance with mental health problems. Our mental health center, like many others across the country (particularly in rural areas),[2] was serving only a small number of persons over age 65. Despite the fact that elderly persons make up more than 12 percent of the population, they account for only 4 percent to 6 percent of the caseload of community mental health centers (CMHCs) nationally and less than 2 percent of the caseload of private psychiatrists.[3] And a community service survey found that 15

Summary Several barriers prevent elderly persons, especially those living in rural areas, from receiving mental health services. The Abbe Center for Community Mental Health is breaking down some of these barriers in the Cedar Rapids, IA, area.

The center's Elderly Outreach Project identifies and provides mental health services to the area's rural elderly. A multidisciplinary team (psychiatrist, nurse, and social worker) assesses and treats homebound clients.

Four major barriers prevent seniors from using traditional mental healthcare services:

- *A lack of trained professionals.* Because many professionals have not received training in geriatrics, those working with elderly clients should be encouraged to attend educational conferences to fill gaps in their knowledge.
- *Organizational barriers.* Transportation and cost may prohibit elderly persons from seeking mental healthcare. Facilities must revise policies detrimental to clients' well-being.
- *Ageism.* Many elderly persons have internalized negative and incorrect beliefs about what aging is or should be. Education about "normal" aging is essential.
- *Stigma.* The stigma of mental illness is particularly troublesome. Services such as in-home counseling allow clients to get the help they need while keeping their mental illness confidential.

To eliminate the barriers to mental healthcare, increased financial resources are necessary to develop, implement, and maintain innovative programs that can reach frail, isolated, hard-to-find persons in need of mental health, medical, and social services.

percent to 25 percent of seniors in our catchment area were in need of mental health services. However, persons over 65 made up only 1.2 percent of the center's caseload, suggesting a tremendous gap between those in need of and those actually receiving mental health services.

The problems in our community paralleled those identified in a 1978 report of the panel on rural mental health (part of the President's Commission on Mental Health). During the past 15 years, little, if any, progress has been made in addressing the mental health needs of the rural elderly. The panel highlighted some of the problems in rural America.

> Rural communities tend to be characterized by higher than average rates of psychiatric disorders, particularly depression, by severe intergenerational conflicts, by an exodus of individuals who might serve as effective role models for coping, by an acceptance of fatalistic attitudes and minimal subscription to the idea that change is possible.[4]

Unlike many rural communities, in the center's service area, mental health services were available in 1986, when the EOP began. In fact, the Abbe Center offered a wide range of outpatient services, including an outreach clinic in the most isolated area. However, seniors in our community did not seek mental health assistance and therefore did not use the available services. This meant many elderly, suffering from depression, dementia, adjustment disorders, care giver stress, late-onset schizophrenia, and other maladies, went without help. Admission patterns at local and state hospitals suggested that older adults looked for assistance only at the point of crisis. Unfortunately, this pattern often resulted in needless suffering and premature (and in some cases inappropriate) institutionalization—institutionalization that may have been prevented had these persons sought mental health services earlier.

Before implementing the EOP, staff at the Abbe Center had to learn why elderly persons waited until they reached a crisis before seeking mental health assistance. They uncovered a number of barriers that prevented the rural elderly from asking for assistance—barriers that had to be surmounted if the EOP was to be successful.

This article presents the most common barriers to mental healthcare faced by the rural elderly and highlights examples and solutions from the EOP's caseload. In addition, it sets forth strategies for overcoming these barriers and discusses the resultant policy implications.

Barriers to Care

A review of the literature[1] and the experiences of EOP's staff during the past six years revealed four major barriers that prevent seniors from seeking mental health services in a psychiatric clinic or mental health center:

- A lack of trained professionals
- Organizational barriers
- Ageism
- Stigma

A Lack of Trained Professionals Many healthcare professionals are not motivated to work with seniors,

Many rural elderly fear institutionalization and wish to continue living independently in the community.

Judy Pedersen

whom they regard as "hopeless cases." And other professionals lack the skills and training necessary to work with this population. Many educational programs preparing mental health professionals fail to adequately discuss late life developmental tasks or problems associated with advanced age, let alone emphasize therapies that are particularly useful with aging clients.

When the EOP was launched, members of the multidisciplinary team had varying educational backgrounds and levels of expertise. Some staff had received advanced education in mental health, others had advanced training in geriatrics and gerontology. Only the project director had expertise in mental health treatment *and* geriatrics.

Through joint case review and treatment planning, staff overcame their limitations. This format encouraged the sharing of knowledge between disciplines, which maximized the potential for comprehensive assessment, accurate diagnosis, and effective treatment and referral. In addition, EOP team members attended educational conferences to fill in the gaps in their knowledge.

Organizational Barriers The problems of distance, time, and expense to reach available services are impediments to many rural residents, particularly the elderly who may not be able to drive because of visual impairments. In addition, the cost of the service can be prohibitive to those on a fixed income.

"Mabel," an 83-year-old widow living alone, became severely depressed, delusional, and anorexic after the death of her husband. Mabel's visiting nurse called the Abbe Center for Community Mental Health (before initiation of the EOP) and asked for help. The "intake process" meant Mabel would need to come to the center, be interviewed by an intake technician, and then be seen by mental health professionals who would later develop a treatment plan. Confronted with these seemingly overwhelming requirements, Mabel refused assessment and treatment. The nurse queried, "Couldn't someone from the center see Mabel in her home? Couldn't they bend the rules in this special case?" The center's answer was, "No. If we do it for one, we'll have to do it for all, and we just don't have the time or resources to provide in-home assessment."

The cost of the service can be prohibitive to those on a fixed income.

"Marie" faced another type of organizational barrier. She refused to sign a release form that allowed the center to bill her insurance for services, which she regarded as charity. Marie appreciated the social worker's assistance and did not want to terminate services, but she was adamant that she could "pay her own way." Before implementation of the EOP, the center's policy was to charge full fees when individuals refused to use the insurance available to them. This meant that Marie would have to pay $74 an hour—a fee she could not afford.

The EOP staff realized they had to examine and revise policies that barred persons from needed services. For example, after initiation of the EOP, a geropsychiatric nurse was able to see Mabel in her own home without all the "necessary" paperwork. Marie was able to continue receiving care and was assessed a fee based on a sliding scale, which enabled her to pay her own way. The Abbe Center's former policy in both these cases had been detrimental to the clients' well-being and impeded the delivery of needed services.

Ageism Americans hold some negative and incorrect beliefs about what aging is or should be. Many elderly persons have internalized these beliefs to some degree. They may think they are incapable of change or unworthy of assistance, or they may believe it is natural to be "old and sad" or that memory loss and confusion are inevitable consequences of the aging process.

"Elsie," an 87-year-old nursing home resident, was labeled "chronically confused" by the staff. Her physician explained to the family that it was "senility" caused by her advanced years. The EOP team urged the family to seek a comprehensive medical workup to rule out other causes of the confusion. Assessment at a nearby geriatric clinic revealed Elsie had a thyroid dysfunction that was responsible for her cognitive symptoms. Her mental status cleared considerably with the needed medication. The confusion was not entirely reversed, however, because the problem had gone undetected and untreated for so long.

Education about normal aging is needed for care givers, the elderly, and their family and friends. Negative attitudes and myths about aging

are still pervasive and must be confronted in multiple ways—through the media's treatment of older adults, educational programs for children and youth, informational materials for families and seniors, and education of healthcare and social service professionals.

In addition, further research about normal, healthy elderly is needed to differentiate between those changes which are associated with aging and those which are the result of disease. Seniors and their families need encouragement to pursue accurate diagnosis and treatment of both physical and mental health problems.

Educational institutions must continue to address the needs of the elderly—in both their formal degree programs and continuing education efforts. Also, the federal government should expand funding for statewide and regional geriatric education centers, especially those serving rural areas.

Stigma The stigma of mental illness is particularly troublesome in rural areas, especially among the elderly, and may take many forms. The Box below suggests strategies for eliminating this stig-

ELIMINATING THE STIGMA OF MENTAL ILLNESS

ma. Many older people are afraid neighbors and friends will find out about their "mental problem" and make them the subject of gossip and the brunt of bad jokes. They also fear being avoided, shunned, or ostracized. Their fears are not always unfounded.

Many Americans believe mental illness is untreatable and irreversible. They view depression as an everyday occurrence that persons should be able to handle on their own. The words "senile" or "demented" strike fear in the hearts of many, especially the elderly. In some cases Alzheimer's disease has elicited a paranoid reaction: People stay away—not understanding, fearing the strange behaviors, and believing they might "catch it."

"Henry," a retired school principal, was referred to the EOP after a stroke left him partially paralyzed and extremely depressed. He welcomed the staff's home visits and was receptive to psychotherapy. Because he was able to drive, the EOP team nurse asked Henry if he would come to Abbe Center to see her. Henry considered the request, but concluded: "I can't. I can't walk through those doors. I drove by your center and tried to imagine going in, but I just can't bear the thought of someone seeing me. They'd think I was nuts." The nurse therefore continued to visit Henry at home.

Many persons continue to believe they will be abandoned or "locked up" if they accept any type of assistance for a mental problem, even though psychotropic medication has virtually eliminated long-term institutionalization as a treatment for mental illness. Many rural elderly value open space and independence and fear institutionalization as a fate worse than death.

Although the focus of the EOP's work is to *prevent* premature institutionalization, many seniors respond to our offer of services by saying, "You're not going to put me away!" or "I don't need any nursing home!" Their suspicions are so strong that we must continually reinforce the idea that we support their wishes to live independently in the community and want to help them achieve that goal. For example, we refer them to additional community-based services such as home-delivered meals and visiting nurses.

Another barrier to care is some persons' belief that they should be able to "handle problems themselves." They view mental health assistance as a sign of personal weakness or even defeat. These attitudes may prevent people from getting needed assistance. In spite of their failing health, limited incomes, and obvious mental distress (depression being the most common), many elderly persons initially resist help of any type. Typically, three or four visits by an EOP team member are needed to achieve a comfort level that permits even the simplest interventions.

"Charles," a farmer in his early sixties, became severely depressed. He fought the depression, saying that he "should be able to shake it." But the depression worsened. Charles eventually turned his hop operation over to his son. He became more and more despondent and even contemplated suicide. With encouragement from his family, he finally saw an EOP psychiatrist who prescribed medication that alleviated his depression. At first the psychiatrist visited Charles at home; eventually Charles went to the mental health center. Charles sheepishly revealed how afraid he was the first time he walked into the mental health center. "I know I shouldn't feel this way," he said. "I know depression is an illness and I shouldn't be ashamed. But I am. If the fellas at the elevator ever heard that I saw a 'shrink,' I'd never hear the end of it! I just don't think that I could live with it." To alleviate Charles's anxiety, the psychiatrist emphasized that depression has a biological basis. It is an illness, just as diabetes is an illness, and both require medication.

Policy Implications To eliminate the barriers to mental healthcare, increased financial resources are necessary—resources to develop and implement innovative programs like the EOP, which can reach frail, isolated, hard-to-find persons in need of mental health, medical, and social services. Federal, state, and local policymakers should consider the following:

- Federal policy is needed to build and maintain mental health programs in rural America.
- Federal and state dollars need to be redirected from custodial care to home care and rehabilitation of the elderly.
- Medicare and Medicaid reimbursement guidelines require reform to include mental health treatment with multiple services.
- Local, state, and federal representatives from aging service networks and mental health providers must provide and support collaborative programs.
- These same representatives must advocate for regulation amendments to accommodate untraditional and innovative service delivery systems.
- Greater communication and cooperation among all levels of government, advocacy groups, and providers must occur to accomplish a comprehensive care system for the rural elderly.

Success Despite No Funding

On the basis of a three-year evaluation (1986-89), we found that the EOP is a cost-effective service delivery system preventing institutionalization of a significant number of rural elderly.[6] EOP services cost $622 a patient for a year. We

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CARE OF THE DYING

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familial traditions. Care for the dying is impoverished if the patient's cultural context and resources are ignored and he or she is treated as simply a technical problem.

Catholic healthcare institutions today are challenged to respect the diversity of the social and religious values of those who work at and are cared for in the institutions. Healthcare professionals will need courage and humility to affirm their own faith while respecting the diversity around them. Catholic healthcare institutions must strive to promote a sensitivity and respect for cultural diversity as they respond to the needs of the dying and those who care for them.

Sensitivity begins by welcoming the expression of cultural diversity and by promising to respect differences. When cultural differences clash with moral convictions and reconciliation seems impossible, the parties in conflict should disengage with as little disruption as possible. But no one should ever be asked to violate deeply held moral convictions.

VALUING EVERY STAGE OF LIFE

Catholic healthcare institutions should implement policies, educational programs, mission effectiveness committees, and ethics committees to respond to the multicultural dimensions of the care of the dying. As the assisted-suicide and euthanasia movement gains strength, Catholic healthcare providers need to pay attention to how cultural factors influence attitudes about care for the dying in order to fashion responses that will not only prompt them to provide compassionate care, but also give clear Catholic witness to the dignity and value of the person at every stage of life. □

EUTHANASIA

Continued from page 43

euthanasia—which otherwise would be unacceptable to them and to society.[12]

I agree with the cardinal. The reasoned and sophisticated arguments against the legalization of euthanasia will never be heard and the real discussion will not take place unless, as individuals and providers of healthcare, we first meet this critical challenge. □

NOTES

1. Joseph Bernardin, "Address: Consistent Ethic of Life Conference," *Consistent Ethic of Life*, Sheed & Ward, Kansas City, MO, 1988, pp. 86-95.
2. Joseph Bernardin, "Euthanasia: Ethical and Legal Challenges," *Origins*, June 9, 1988, p. 52.
3. Arthur J. Dyck, "An Alternative to the Ethics of Euthanasia," as cited in Richard M. Gula, *What Are They Saying about Euthanasia?* Paulist Press, Mahwah, NJ, 1986, p. 169. These reflections are deeply indebted to Fr. Gula's masterful analysis of this important subject.
4. Gula, p. 70.
5. Courtney S. Campbell, "Religious Ethics and Active Euthanasia in a Pluralistic Society," *Kennedy Institute of Ethics Journal*, vol. 2, 1992, pp. 253-284.
6. Edward Shils, "The Sanctity of Life," in Daniel H. Labby, ed., *Life or Death: Ethics and Options*, University of Washington Press, Seattle, 1968, p. 12.
7. Gula, p. 97.
8. Gula, p. 70.
9. Gula, p. 71.
10. Ron Hamel and Edwin DuBose, "Views of Major Faith Traditions," in Ron Hamel, ed., *Active Euthanasia, Religion and the Public Debate*, Park Ridge Center, Chicago, 1991.
11. Robert N. Bellah, *Habits of the Heart: Individualism and Commitment in American Life*, HarperCollins, New York City, 1986.
12. Bernardin, "Euthanasia," p. 56.

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found this to be substantially lower than costs reported by a group of area mental healthcare providers. Yet, in spite of its success, no local, state, or federal funding bodies offered support of the project after the grant period. Elderly Services (formerly the EOP) is now a permanent part of the Abbe Center for Community Mental Health. It has continued only because of the center's commitment to services for the elderly and its diversion of profits from other programs to support the program.

The EOP is not the first successful and innovative service to experience this difficulty. However, our experience reinforces the need for state and federal planners to reexamine existing policies and to review methods to fund and sustain successful service delivery programs, especially those serving the rural elderly. □

NOTES

1. For a description and evaluation of the Elderly Outreach Project, see Kathleen C. Buckwalter et al., "Mental Health Services of the Rural Elderly Outreach Program," *Gerontologist*, March 1991, pp. 408-412.
2. J. A. Krout, *The Aged in Rural America*, Greenwood Press, Westport, CT, 1986.
3. M. D. Kermis, "Equity and Policy Issues in Mental Health Care of the Elderly: Dilemmas, Deinstitutionalization, and DRG's," *Journal of Applied Gerontology*, September 1987, pp. 268-283.
4. President's Commission on Mental Health, *Task Panel on Rural Mental Health*, vol. 3, appendix, U.S. Government Printing Office, Washington, DC, 1978, p. 1,164.
5. R. Raschko, "Systems Integration at the Program Level: Aging and Mental Health," *Gerontologist*, October 1985, pp. 460-463; Kermis; B. D. Lebowitz, E. Light, and F. Bailey, "Mental Health Center Services for the Elderly: The Impact of Coordination with Area Agencies on Aging," *Gerontologist*, December 1987, pp. 699-702.
6. Buckwalter et al.

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